Côte d'Ivoire

Country Operational Plan

(COP/ROP) 2021

Strategic Direction Summary

May 17, 2021

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1.0 Goal Statement

The President's Emergency Plan for AIDS Relief (PEPFAR) program in Côte d'Ivoire's (PEPFAR-CI) vision for the Fiscal Year (FY) 2022 is focused on addressing systemic barriers, improving quality of care and that key policies are implemented to achieve the Joint United Nations Program on HIV/AIDS (UNAIDS) 95:95:95 goals. Under the leadership of the Government of Côte d'Ivoire (GoCI), PEPFAR-CI and stakeholders have adopted these goals to address specific gaps in the program:

1. Policy alignment & implementation for patient centered care in the era of COVID-19: accelerating TLD, MMD, community ARV
2. Improve service quality and data quality, integrity, and transparency: continuous quality improvement to improve case finding, continuity of treatment, viral load coverage (VLC), and viral load suppression (VLS); strengthen partner management and information systems to better inform decision-making
3. Reduce morbidity & mortality, particularly among children and adolescents: improve VLC/VLS, strengthen services for advanced HIV disease, intensify clinical and case management for children and young people living with HIV (CAYPLHIV)
4. Reduce stigma & increase community engagement: community-led monitoring, faith and community initiative (FCI), increased collaboration with KP and other civil society partners
5. Strengthening the nation's supply chain system, expanding technical support from the central level to last mile delivery while closely partnering with the GoCI to transition commodity procurement to the government.

In FY 2022, PEPFAR-CI will focus on supporting strategic facilities and surrounding communities within 79 districts, representing 93% of all ART patients in the country. These sites will be capacitated to deliver a package of services that address specific programmatic gaps (e.g., targeted case-finding, men-friendly services, improved pediatric case-management, reducing treatment interruption, and improving viral load coverage and suppression), and calibrated by patient needs. This approach will allow clinical and community implementing partners to prioritize improving quality in the areas of greatest need. Côte d'Ivoire has made progress on the TLD transition and accelerating MMD in the COVID-19 context, but additional work remains to ensure that policy updates are implemented at the point of service delivery and that all populations are reached. A major focus of the PEPFAR-CI program will be to accelerate TLD coverage among women of childbearing potential, and DTG-based regimens for children given the viral load suppression gaps and urgency of reducing HIV-related mortality.

PEPFAR's supply chain investments will further support these priorities. In COP21 oversight and capacity building interventions will be strengthened at the decentralized level to ensure sufficient supply for TLD scale up and other life-saving HIV services, for priority districts and sites in need. PEPFAR-CI will continue to strengthen local and government capacity by supporting high functioning procurement and logistics systems at the national-level to ensure safe, secure reliable and sustainable HIV commodities throughout the country. PEPFAR will continue working in

collaboration with the GF and the GoCI to ensure timely and sufficient procurement of high-quality HIV commodities aligned with FY22 needs.

PEPFAR-CI and MSHP leadership will strengthen the framework for collaboration between clinical and community implementing partners, to ensure that services are centered around the needs of patients along the continuum of HIV care and prevention services. Additional focus on increasing VLC at site level from 84% to 96% and VLS from 87% to 95% in FY2022 is essential to monitoring the impact of the response and reaching epidemic control. Given that a significant portion of the Ivoirian population is under the age of 15 (~42%), interrupting transmission, achieving VLS, and primary prevention activities are critical for ensuring that Cote d'Ivoire is able to achieve epidemic control and avoid a resurgence of HIV among young people in the coming years. Populations with low prevalence but high vulnerabilities – children with HIV, orphans and vulnerable children (OVC), and adolescent girls and young women (AGYW); OVC and DREAMS funding accounts for 21% of the PEFPAR Côte d'Ivoire program, and these investments will be better calibrated to accelerate efforts towards epidemic control. The continued efforts geared towards removing barriers to, and accelerating scale up of targeted pre-exposure prophylaxis (PrEP) among high-risk groups (AGYW, key populations, and sero-discordant couples) remains a critical element in FY2022 for averting new infections.

The program is addressing Côte d'Ivoire's unacceptably high HIV-related mortality by increasing opportunities for early HIV diagnosis with index-, self-, and targeted-testing; expanding the continuous quality improvement program; increasing access to early infant diagnosis (EID); ensuring same day ART initiation; expanding MMD and community ART; implementing an advanced HIV disease package; and scaling up of TB preventive therapy. Moreover, facility and community-based interventions (including community health posts) will reduce HIV-related mortality among men through accelerated case finding and reduced treatment interruption. Among these interventions will be partnership with faith-based institutions to disseminate U=U and stigma-reduction messaging, the importance of early diagnosis, and the reality of a healthy, productive life on ART. Expansion of high-quality clinical services and strengthening community-level engagement will be key opportunities to improve HIV care, reduce stigma, and prevent new HIV infections among key populations. Finally, expanding the community-led monitoring program will broaden PEPFAR-CI's civil society engagement and ensure that patient and community perspectives inform programmatic decision-making.

PEPFAR-CI continues to work in close collaboration and partnership with GoCI leadership to improve monitoring and program performance through data-driven decision making, leveraging multi-level engagement with stakeholders and the Embassy Front Office.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Côte d'Ivoire had an estimated total population of 26,453,542 in 2020 (National Institute of Statistics - INS) of which males account for 51.3% (13,579,723) and females 48.7% (12,873,818). The estimated Ivoirian population under 15 years of age is 11,271,234, or 42.2%. The 2017/2018 population-based HIV Impact Assessment (PHIA) found an HIV prevalence of 2.9% for 15 to 64-year-olds. PHIA also found a prevalence of 2.5% among the 15 to 49-year-old population, which is much lower than the 3.7% reported in the 2011/2012 DHS for the same age group. Much higher estimates exist among female sex workers (FSW) and men who have sex with men (MSM) (11.4%[1] and 12.33% respectively). The 2021 UNAIDS Spectrum estimates, using the PHIA results, noted a total PLHIV of 379,594 including 21,273 children living with HIV as of December 2020, and approximately 11,000 children living with HIV and 15,000 pregnant women needing ARVs. An estimated 280,848 of PLHIV (74%) are on treatment, leaving a gap of 98,746 PLHIV not on treatment. In 2020, there were approximately 6,200 new HIV infections (1,200 among children) and 9,400 AIDS-related deaths in Côte d'Ivoire.

Côte d'Ivoire has worked steadily towards reaching HIV epidemic control over the past sixteen years. With a total PEPFAR-CI investment of almost $1.7 billion from 2004 to date, an investment from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) of $390 million from 2004-up to date, and increasing GoCI financial contributions and efforts, the number of PLHIV on antiretroviral therapy (ART) has increased from 4,536 in 2004 to 280,848 in 2020. Of these, 236,464 patients (84%) are receiving care at 516 ART facilities supported by PEFPAR as of FY2021 Q1. The success of Option B+ is contributing to the achievement of the first 95 goal, specifically for women, of the Joint United Nations Program on HIV/AIDS (UNAIDS) 95:95:95 goals. While gaps remain in the first 95 and third 95, particularly among children (48.6% know HIV status; 66% viral suppression among PLHIV on ART) and men (68% know HIV status) – Cote d'Ivoire has achieved 96.5% for the second 95. Further, current FY2021 Q1 results demonstrate a 90% linkage rate among PEPFAR-supported sites and catchment areas.

Despite these advances, the country still faces obstacles in achieving epidemic control. While continuity of treatment has improved, gaps still exist in identifying HIV-infected men, women outside of ANC, and children, as well as linking them to, and keeping them on treatment. The ART gap among adult women also remains high and coverage among men and children remains low. Viral suppression among children 0-14 years old (59%) also remains low, with varying rates among fine age bands at PSNU level (ranging from 16 to 90%). Gaps along the clinical cascade are significantly greater for men, where most HIV-positive young and adolescent men remain unidentified and most men 25+ who are diagnosed are not on treatment; as a result, the community VLS rate for men >15 remains under 50%. Adolescent girls and young women face unique risks to

[1] Johns Hopkins University, Enda Sante, "Etude de la Prévalence, de la Prévention, et de la Prise en Charge du VIH Chez les Populations Clés en Côte d'Ivoire, 2014."

HIV infection and barriers to services, including unacceptably high rates of violence: one in five females (19.2%) experience sexual violence before the age of 18.[2]

Recent measures by the GoCI and intensified PEPFAR-CI efforts are addressing these deficits. Beginning in January 2017, President Alassane Ouattara has focused more attention on the health sector, though this sector has historically seen less public investment than infrastructure, education, and other sectors contributing to strong economic growth. In 2018, the Ivorian authorities launched the rehabilitation and upgrading of three regional hospital centers (RHC) and five general hospitals (GH) at a cost of around $180 million. In addition, in 2020 the Ivorian Ministry of Health adopted a project for the construction and rehabilitation of 500 first-contact health facilities across the country. The project-based investment is approximately $316 million. The national policy aligns with PEPFAR-CI's strategy on focused testing to increase effectiveness of case finding and linkage to treatment, with written guidance distributed in October 2017. Between FY20Q1 and FY21Q1, following the lifting of COP18's testing pause (FY19Q3 – FY19Q4), facility-based provider-initiated testing and counseling (PITC) testing yields outside of ANC increased by 41% across the 139 COP19 prioritized sites. Other PEPFAR-supported sites only increased yields by 17% over the same period (FY20Q1 -FY21Q1). Challenges remain in the widespread implementation of targeted testing across all sites where lower volume, non-prioritized sites conducted over 60% of tests while supporting only 37% of total TX_CURR.

As an update to the February 2020 circular that reiterated the importance of rapid transition to TLD, differentiated service delivery (e.g. 3-6 MMD for stable patients[3], community ART dispensation) and TB preventive treatment (TPT) for all eligible ART patients, the Ministry of Health issued a notice on October 15, 2020 recommending 6-MMD for all adult PLHIV (stable and unstable) and reinforcing the provisions related to TLD transition, TPT and community ARV distribution as part of the Programme Nationale de Lutte Contre SIDA (PNLS) COVID-19 contingency plan. Weekly monitoring shows the proportion of patients on TLD continues to increase with 61% coverage among PEPFAR supported sites as of March 2021 (up from 30% in February 2020). As of March 2021, 82% percent of all patients are on multi-month dispensing (3-5 MMD; 48%; 6MMD: 34%) according to FY21 Q2 data from DATIM. Unfortunately, barriers to these interventions remain for certain populations. For example, women of childbearing age still lag behind men in TLD transition partly due to the circular's disproportionate emphasis and inaccurate representation of risks, rather than the undisputed benefits to the infant and viral suppression of the mother. In order to achieve 95:95:95 goals in Côte d'Ivoire, PEPFAR programming in FY2022 will require further attention to address critical programmatic and systems gaps in: continuity of treatment, particularly among young people (20-40 years of age); case identification across all populations, particularly men, women outside of ANC, and children; strengthening linkage to services; access to and uptake of VL testing; VLS rates, particularly among men who represent the highest risk for ongoing transmission, young women and children who have

[2] MFFE. *Violence Against Children and Youth in Côte d'Ivoire: Findings from a National Survey.* (Abidjan: MFFE, 2020). https://www.togetherforgirls.org/wp-content/uploads/2020/09/Cote-dIvoire-VACS-Report_English.pdf (Accessed 6/4/21)

[3] MSHP, Note Circulaire 02160, 19 Mars 2019

the lowest rates of suppression; and data quality issues jeopardizing the ability to adequately interpret, plan, and appropriately manage program activities.

Tables 2.1.1 and 2.1.2 provide an overview of GoCI's health statistics, specific to HIV, PMTCT, OVC and KPs, showing a 2.1% HIV prevalence with 370,676 PLHIV.

Table 2.1.1 Côte d'Ivoire epidemiological context. This table provides a summary of HIV data for Côte d'Ivoire, with demographic data, HIV prevalence and Key population sizes.

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population (2021)	27,297,322		5,643,290	20.7 %	5,702,507	20.9 %	2,798,434	10.3 %	2,792,179	10.2 %	5,136,191	18.8 %	5,224,721	19.1 %	Spectrum 2021
HIV Prevalence (%)		2.1 (age 15-49)		0.18 %		0.18%		0.72 %		0.46 %		3.99 %		0.18 %	Spectrum 2021
AIDS Deaths (per year)	9,400		395		402		399		464		3,515		4,225		Spectrum 2021
# PLHIV	370,676		9,126		9,298		22,823		14,603		210,502		104,324		Spectrum 2021
Incidence Rate (Yr) per 1,000		0.24		0.096		0.096		1.02		0.12		0.28		0.24	Spectrum 2021
New Infections (Yr)	6,150		584	9%	599	10%	1,330	22%	306	5%	1,886	31%	1,444	23%	Spectrum 2021

Annual births	1,221,815														National program
% of Pregnant Women with at least one ANC visit		85	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A			MICS Survey 2016
Pregnant women needing ARVs	15,000														Spectrum 2021
Orphans (maternal, paternal, double)	230,000		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		UNAIDS report 2019
Notified TB cases (Yr)	25,299		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		2014 National TB Program routine data
% of TB cases that are HIV infected	5,551		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		2014 National TB Program routine data
% of Males Circumcised	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A	

Estimated Population Size of MSM*	49,018														Program Estimates 2021
MSM HIV Prevalence		12													IBBS 2015-2016
Estimated Population Size of FSW	75,412														Program Estimates 2021
FSW HIV Prevalence		11													IBBS 2014
Estimated Population Size of PWID	Data N/A	Data N/A													
PWID HIV Prevalence	Data N/A	Data N/A													
Estimated Size of Priority Populations (Military)	40,000	3.4	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	SABERS 2014
Estimated Size of Priority Populations Prevalence (specify)	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression. This table provides a summary of the epidemiological context of Côte d'Ivoire, with demographic data, HIV prevalence and Key population sizes

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	27,297,322	2.1. (age 15- 49)	370,676	301,550	284,528	77%	87%	1,396,127	37,113	33,045
Population <15 years	11,345,797	0.18	18,424	9,717	10,425	57%	69%	124,450	1,235	1,383
Men 15-24 years	2,792,179	0.46	14,603	9,789	8,995	62%	74%	56,491	932	691
Men 25+ years	5,224,721	1.8	104,324	79,990	70,283	67%	89%	210,695	10,753	9,223
Women 15-24 years	2,798,434	0.72	22,823	17,278	17,597	77%	77%	371,878	3,486	3,096
Women 25+ years	5,136,191	3.99	210,502	184,776	177,228	84%	88%	632,612	20,707	18,652

MSM	49018	11.6						9,591	1,265	518
FSW	75412	11.4						17,582	1,970	357
PWID	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A
Priority Pop (specify)	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A

*Source: national data: National Institute of Statistics 2021 (population data), National AIDS Control Program 2021 (program data), UNAIDS Spectrum estimates 2021 (Prevalence, PLHIV)

Figures 2.1.1 – 2.1.4 show key indicators in epidemiological data related to HIV, including the number of people on ART and new HIV infections in comparison to mortality among PLHIV.

Figure 2.1.1 Updated National and PEPFAR Trend for Individuals currently on Treatment*

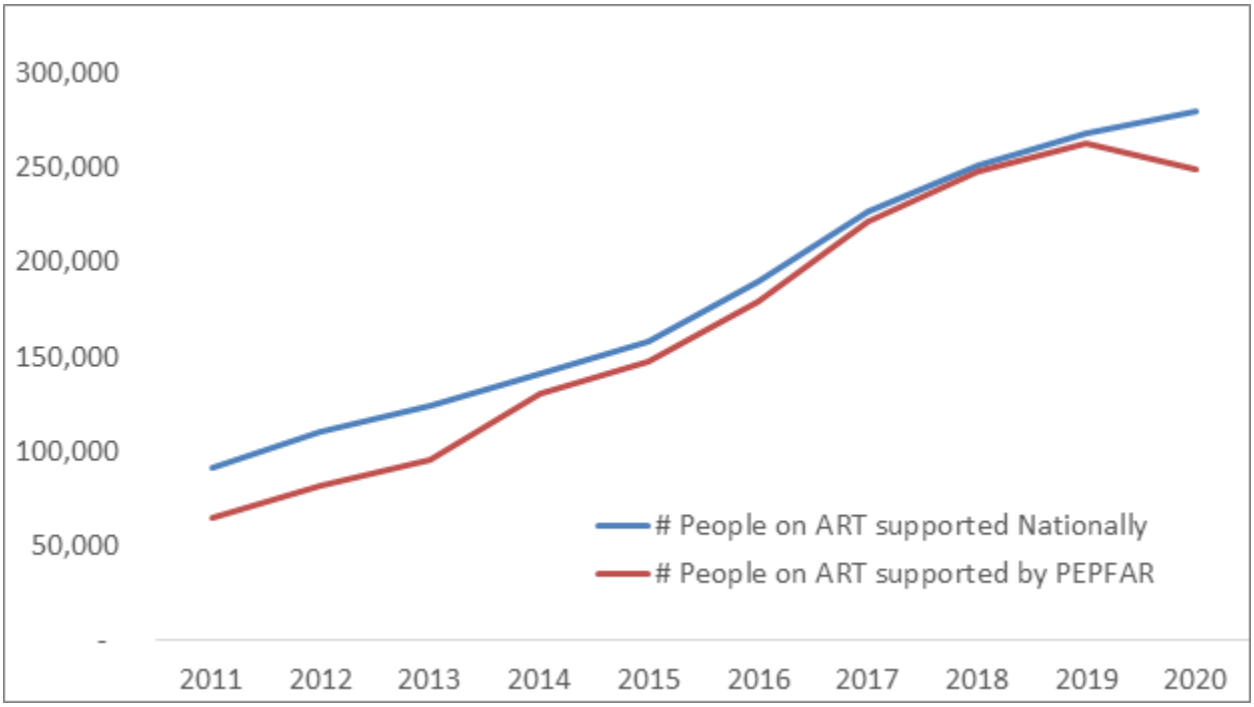


Figure 2.1.2 Updated Trend of New Infections and All-Cause Mortality Among PLHIV*

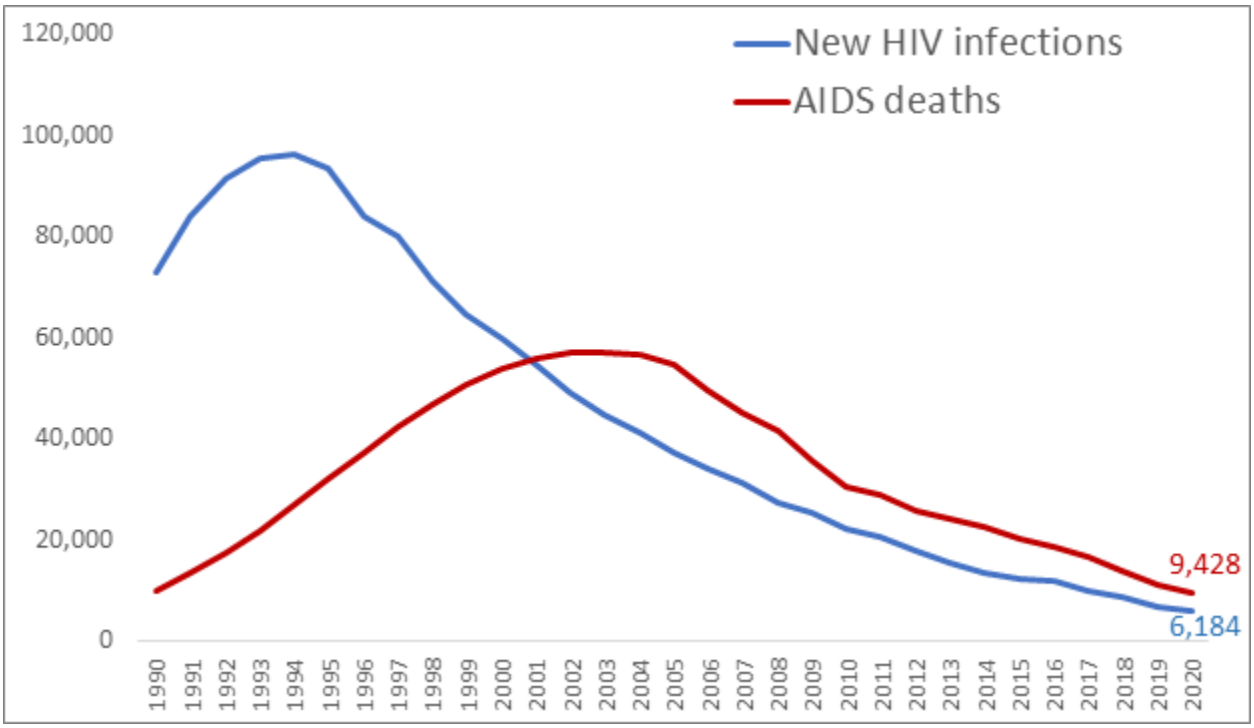


Figure 2.1.3 Updated Trend of New Infections and All-Cause Mortality Among Men*

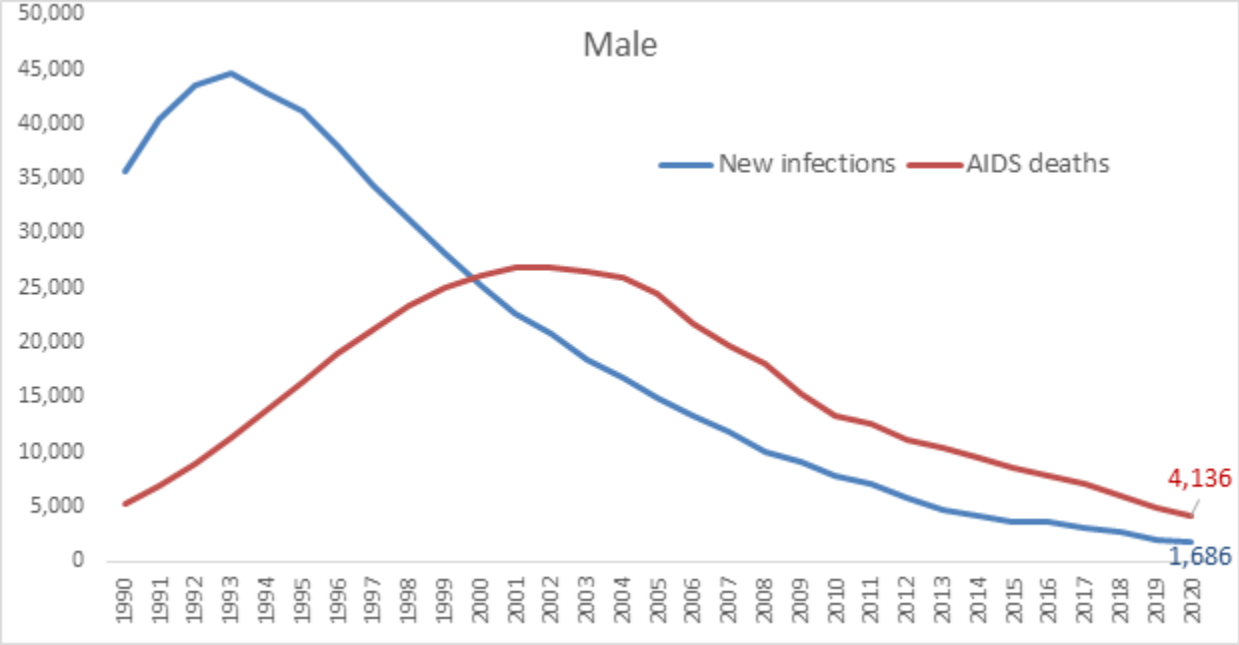
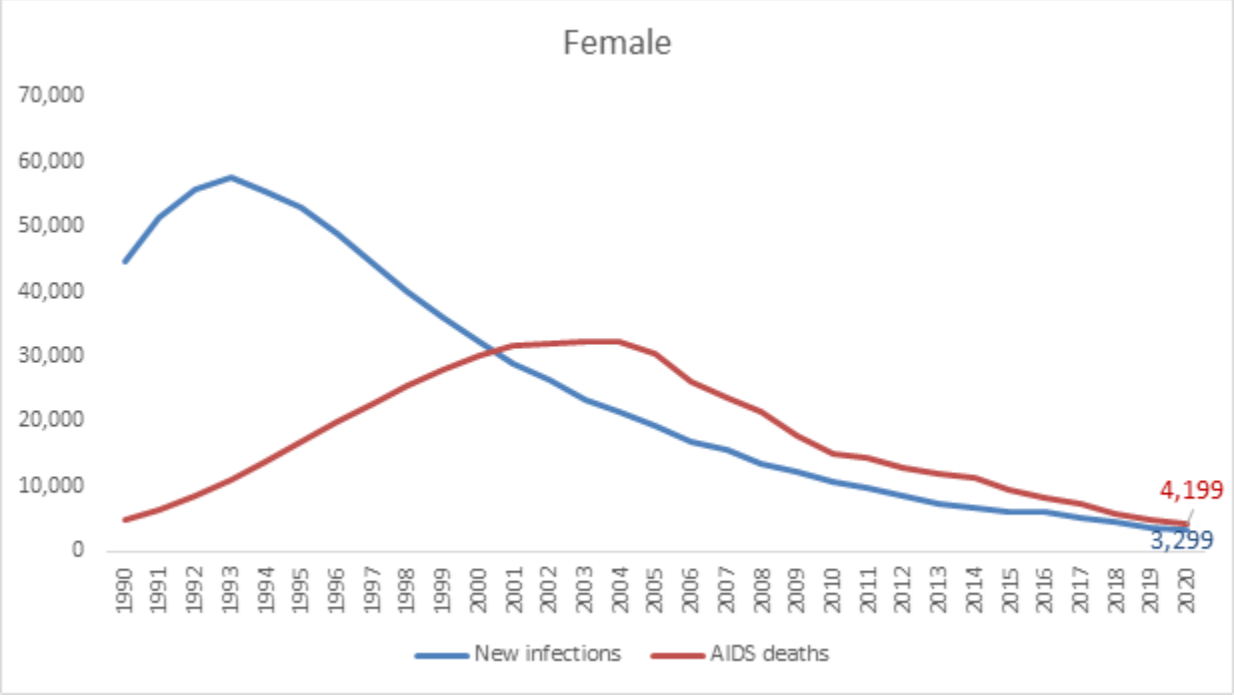


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among Women*



*These data are pulled directly from most recent Spectrum Estimates (2021) for the period of 1990 to 2020.

Figures 2.1.5 illustrates the progress in retaining individuals in lifelong ART between FY2020 Q2 and FY2021 Q2.

Figure 2.1.5 Progress retaining individuals in lifelong ART in FY2020 Q2 – FY2021 Q2
(n = 917 sites reporting on TX_CURR in FY2020; n = 516 sites reporting on TX_CURR at FY2021 Q1)

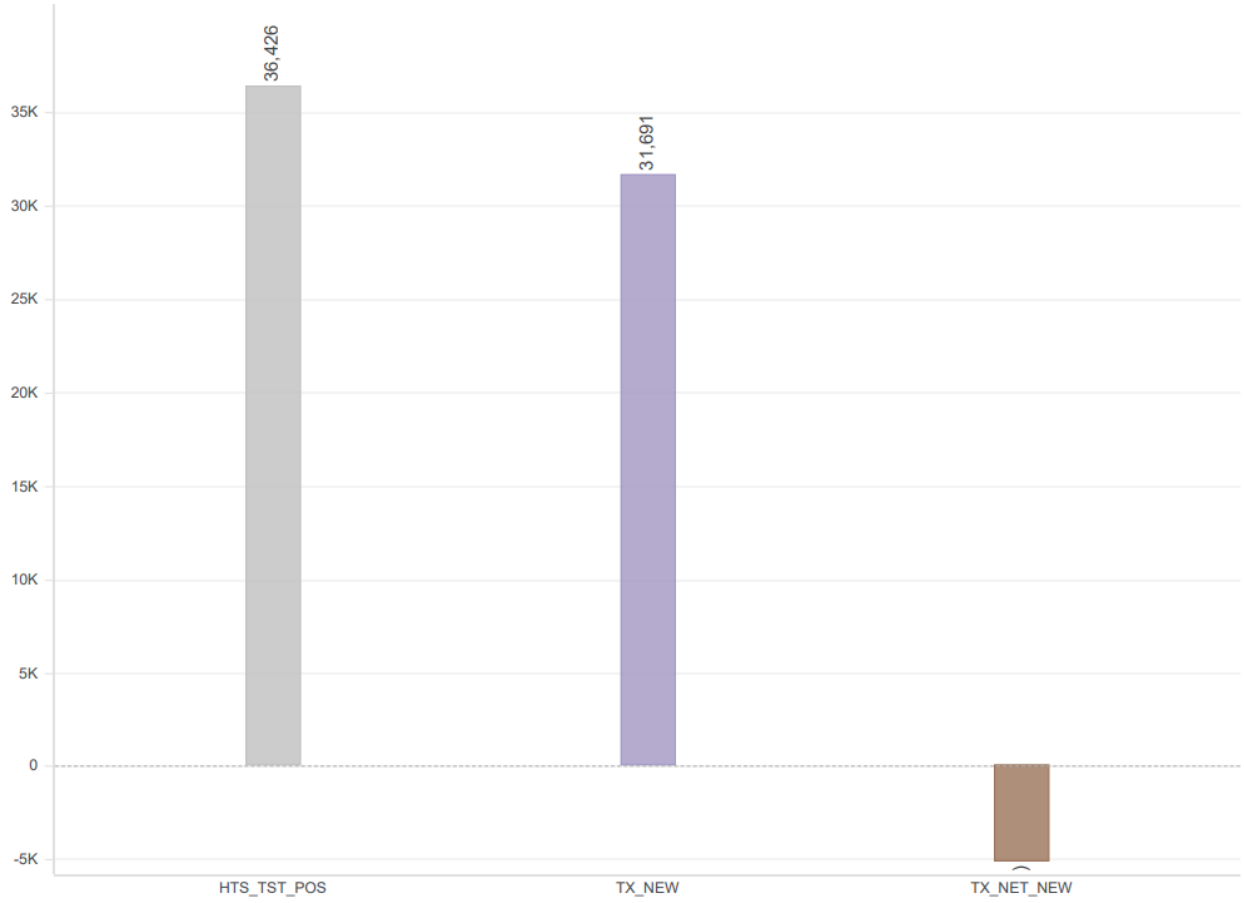


Figure 2.1.6 provides the sex and age of patients not retained on treatment in FY2021 Q2.

Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY2021 Q2

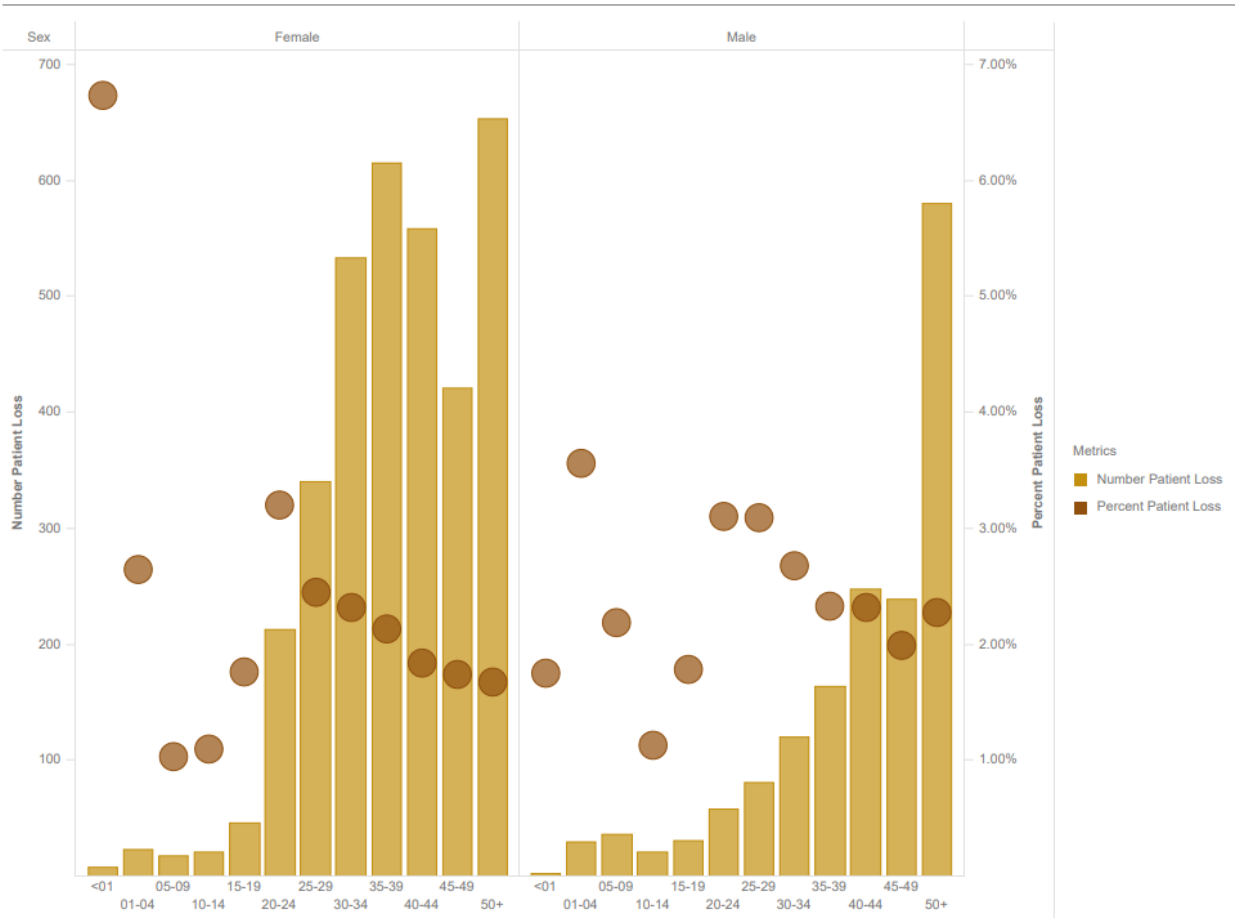


Figure 2.1.8 illustrates the estimated 99,000-person treatment gap as well the gap in case finding.

Figure 2.1.8 Epidemiologic Trends and Program Response

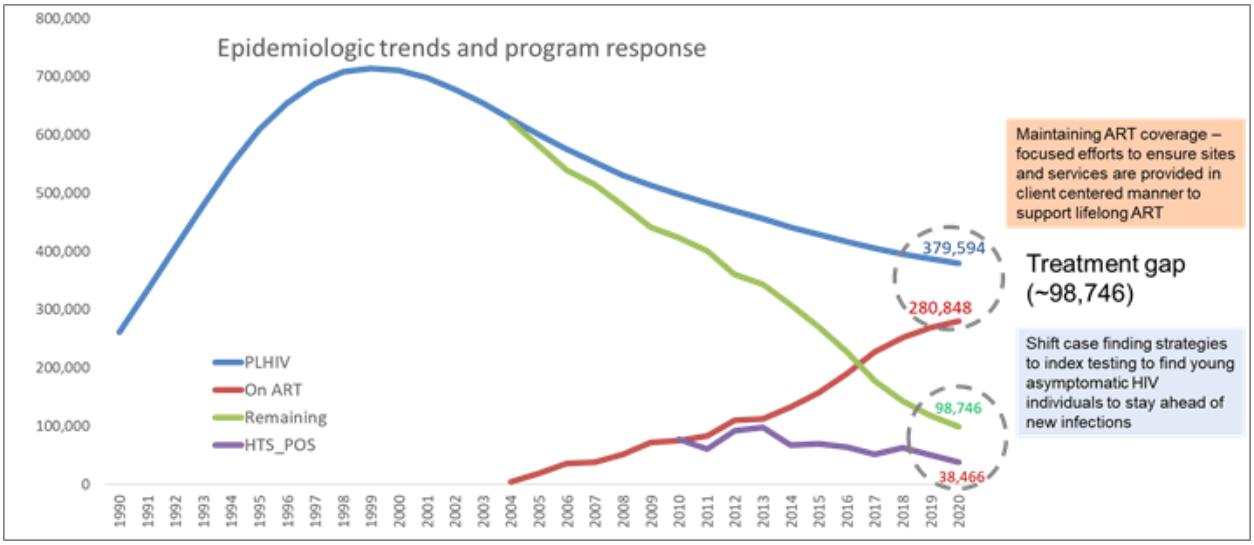
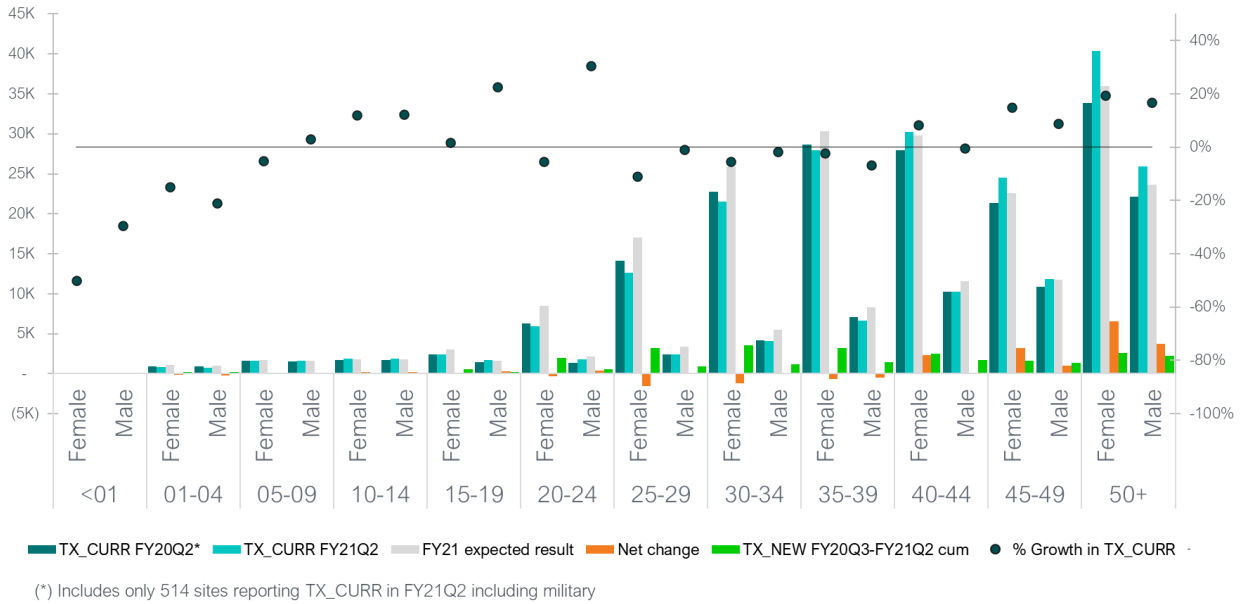


Figure 2.1.9 shows the HIV treatment growth by age and sex to pinpoint where specific areas of intervention are needed to maintain and grow the HIV treatment population (Net change in HIV treatment by sex and age bands 2019 Q4 to 2020 Q4).

Figure 2.1.9 Côte d'Ivoire Treatment Growth, FY2020 Q3 – FY2021 Q2, All Prioritized SNU



2.2 New Activities and Areas of Focus for COP21, Including Focus on Continuity of Treatment and Quality of Service Delivery

In the COP21 framework, PEPFAR investments will support clinical services primarily through the public sector health care system, working with the MSPH staff, including doctors, nurses, midwives, pharmacists, laboratory staff and data managers through an approach that integrates HIV services with other health programs.

Within that framework, PEPFAR-Côte d'Ivoire (PEPFAR-CI) is shifting resources toward site-level, patient-centered service delivery support that has a more direct impact on quality HIV testing and treatment service provision for an increasing number of patients. A significant emphasis will be placed on continuous quality improvement: (1) service delivery quality to improve long-term viral suppression among all sub-populations and reduce HIV-related mortality; and (2) data integrity given the challenges the program has faced over recent years. The program will also focus on strengthening collaboration between clinical and community implementing partners to streamline services so that they are patient centered, and to improve data quality and transparency across the continuum. Best practices and innovative strategies aimed at improving case finding, ensuring continuity of treatment for HIV positive clients across all age bands on treatment, and viral load suppression will be disseminated and scaled across both community and facility partners. Site-level support includes the mentoring and coaching of service providers, quality improvement oversight of services, provision of supplies and equipment, staff salary support, provision of tools and standard operating procedures (SOPs), minor rehabilitation, and support for sample transportation. This package of services will be calibrated based on patient-needs of each site, and the limited resources available.

Specifically, COP21 will focus on the following new activities to improve client linkage and continuity of treatment:

- Improve quality of care and delivering patient-centered services to meet the needs of prioritized populations who are historically hard to reach and/or underserved in Côte d'Ivoire:
    - Expand male-friendly services to address ART gaps and reach men. Strategies will include extended hours of service and integration of HIV services into a wellness/multi-disease screening approach for men, and targeted community mobile testing at various men gathering places. In addition, through the Faith and Communities Initiative, PEPFAR-CI will be implementing Zambia's Circle of Hope model of community health posts in one health district, to improve case-finding, ART initiation, VL services and treatment literacy in locations where men congregate.
    - Expand differentiated clinical services for key populations (KP) to encompass additional facilities. Recognizing that KP clients choose to receive services based on their own needs and convenience, PEPFAR-CI will provide targeted support to clinical facilities with high volumes of KP patients in order to ensure high-quality

care. Children of FSWs, having shown high testing yields in PEFPAR-CI, will also be reached through this approach, and linked to relevant HIV services in an effort to close the gap on pediatric ART coverage and reduce HIV-related mortality among children. Furthermore, community lay workers and peer educators will carry out DBS sample collection and deliver treatment literacy messages to improve VLS among KP clients.

- Scale up clinical and community support for children and adolescents. PEPFAR-CI will expand its pediatric focus from 95 to 235 facilities, providing dedicated staff and intensified case management to improve VLC and VLS. Increased mentorship and collaboration with OVC partners will complement these efforts at the community level, supporting parents/caregivers on ARV administration for infants, toddlers, and young children. Additionally, home visits will improve linkage for children diagnosed through EID, and facilitate additional support to the family unit, for older children and adolescents struggling with adherence and continuity of treatment. The oversight of pediatric programmatic activities that was attributed to the Pediatric and Adolescent Task Force in Cop20 would continue in COP21 under the established interagency technical working groups for prevention, case finding, continuity of treatment, viral load suppression and supply chain.
- Expand community ARV distribution, building on COVID-19 adaptations. Aligned with the scale up of TLD, 6-MMD, and the differentiated support that will be provided to PLHIVs in COP21, is the roll out of community ARV distribution. Existing community structures, such as PLHIV support groups and other existing outreach platforms will be leveraged to facilitate patient access to ARVs while strengthening support for continuity of treatment and adherence. Models most appropriate to the Ivoirian context will be formalized in consultation with MSPH and Civil Society Organizations (CSOs) over the course of COP20 for rapid implementation in COP21, with an emphasis on effectiveness of patient outcomes.
- Scale up the implementation of CommCare, a tablet-based, patient-level case management system that currently allows facility and community health workers to track patients and identify missed appointments, and the expansion of its functionality to include tracking of linkage to treatment, TPT, and upcoming or missed viral load appointments. With approval from MSHP at the beginning of COP20, CommCare is currently being rolled out to 139 COP19 priority sites. In COP21, the system will be rolled out to an additional 34 sites to ensure coverage of all 173 high impact sites including the deployment of the HTS-index, TPT and VL appointment tracking modules to all high impact sites and will be synchronized with the Ministry's SIGDEP facility-based electronic health record. Facility-level dashboards will also facilitate monthly coordination meetings with facility and community IPs, to facilitate individual patient management. Finally, and perhaps most critically, CommCare will support other PEPFAR-CI efforts to improve data quality and integrity on linkage of HIV-positive individuals identified in the community, which has been a recurrent challenge for the program.

- Partner with faith communities to reduce stigma and strengthen HIV and treatment literacy for improved HIV outcomes across the clinical cascade. Through this strategy, PEPFAR-CI's implementing partners will reproduce and share materials including *Messages of Hope* to reduce HIV stigma and discrimination and strengthen demand for HIV services. Workshops and trainings with faith leaders will be held to identify opportunities for increased faith community involvement and strengthen their capacity to support interventions for HIV prevention, case finding and care and support of PLHIV. Among the key issues addressed will be HIV stigma and the need for strengthened HIV literacy.
- Roll out a package of services in order to reduce mortality among clients with advanced HIV disease. In COP21, PEPFAR-CI will scale up the following services at 60 high volume and military sites, targeting adults and children with advanced disease: rapid initiation of ART, TB screening and testing (including TB-LAM, TB testing with WHO-approved rapid molecular tests) and treatment, TB preventive therapy (TPT) for TB-negative PLHIV receiving ART, cryptococcal antigen screening and fluconazole pre-emptive therapy for CrAg positive clients without evidence of meningitis, cotrimoxazole preventive therapy (CPT), and tailored adherence counseling and support to ensure optimal adherence to the advanced disease package, including home visits.
- Implement safe and ethical index testing, including monitoring of intimate partner violence (IPV), with fidelity at scale as a key means of case finding in COP21. Given the country's progress towards epidemic control, index testing must play an increasingly central role in efficient case finding. This will require improvements in contact elicitation and empathetic, patient-centered communication among providers. Greater follow-up is needed to ensure effective implementation of SOPs for improved effectiveness and reach while ensuring World Health Organization (WHO) standards are respected and adherence to PEPFAR Safe and Ethical Index Testing Standards.
- Expand community-led monitoring. PEPFAR-CI has been steadily increasing its engagement and collaboration with civil society throughout the COP development and implementation processes. Community-led monitoring will ensure that patient and community voices inform quality improvement and programmatic decision-making. PEPFAR-CI will leverage community insights and monitoring for key population prevention and treatment services as well as for improving treatment literacy and reducing stigma for all PLHIV.
- Strengthen Gender Based Violence (GBV) response. Recent VACS and programmatic data reveal disturbing levels of physical and sexual violence suffered by AGYW throughout the country, and particularly poor reporting in DREAMS districts. While community efforts are critical to identify GBV victims, clinical facilities must be equipped to respond with youth-friendly services including SRH, pre-exposure prophylaxis (PEP), PrEP, psychosocial support, and evidence collection for possible legal action. In COP21, PEPFAR-CI will strengthen these

clinical services through the DREAMS program in an effort to improve GBV reporting and response.

- Conduct an OU-wide formal data quality assessment as part of the Continuous Quality Improvement activities to address data integrity and data quality challenges identified in COP19 and Cop20. Site-level technical assistance will be provided to clinical and community IPs to address clinical and community site-level data integrity across PEPFAR indicators, especially case finding, continuity of care, and VLS. Coaching will leverage previous and current DQA work and scale-up of weekly data quality reporting tools.

2.3 Investment Profile

The GoCI is committed to ensuring equitable access to quality health services for all Ivoirians as outlined in the 2016-2020 National Health Development Plan (PNDS). The 2021-2025 PNDS is currently in development. To establish greater coherence between its development objectives and its budgetary capacities, Côte d'Ivoire has adopted the program budget system. The GoCI had signed up for the Global Financing Facility (GFF), a country-led and innovative approach to financing, which will help significantly increase investments in health. As a catalyst for a health investment platform, the GFF supported the development of the investment case to prioritize high-impact interventions required to achieve the goals set in the health development plan. As stated in the 2020-2023 Investment Case for Health launched during the National Dialogue on Health Financing in April 15-18, 2019, the health budget represents 6% of the national total budget. This is very low despite the continuous economic growth that Côte d'Ivoire has experienced during the past seven years (prior to the COVID-19 pandemic). Household payments and foreign investments cover 60% of the total health expenditures. This high dependency on external resources is a serious vulnerability for continuity of funding for health services.

An analysis of the investments in the health sector from 2016-2018 suggests that the U.S. government was the largest foreign contributor to health, accounting for 15% of heath investments, second to the GoCI with 62.05% (which also includes household and private sector expenses). The 2016 National Health Accounts reported that household out-of-pocket represents 35.8% of the total health expenditure. However in 2019, the GoCI released a Circular Note and a decree that clarified the 2014 law, which mandates the free provision of HIV-associated care and treatment at public and private health facilities.

The Ministry of Health and Public Hygiene has launched several reforms and initiatives to mobilize additional resources and improve public financial management in health. Reforms focus on expanding protection of financial risk through a national health insurance scheme; increasing access to quality maternal and child services with critical medicines and supplies; and strengthening health sector governance.

There has not been a National AIDS expenditure assessment in Côte d'Ivoire since 2012. Table 2.3.1 below illustrates the most recent financial information on health investments in Côte d'Ivoire and Table 2.3.2 represents donor investment for HIV commodities.

Table 2.3.1: Investment Profile for HIV Programs

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2021
Care and Treatment	$79,368,535	14%	17%	69%	0%	
HIV Care and Clinical Services	$49,119,700	0%	23%	77%	0%	
Laboratory Services incl. Treatment Monitoring	$10,240,712	1%	3%	96%	0%	
Care and Treatment (Not Disaggregated)	$20,008,123	55%	10%	35%	0%	
HIV Testing Services	$11,564,955	4%	8%	88%	0%	
Facility-Based Testing	$5,934,642	8%	7%	85%	0%	
Community-Based Testing	$4,826,383	0%	8%	92%	0%	
HIV Testing Services (Not Disaggregated)	$803,930	3%	8%	89%	0%	
Prevention	$15,387,281	17%	31%	52%	0%	
Community mobilization, behavior and norms change	$4,935,935	0%	31%	69%	0%	
Voluntary Medical Male Circumcision	$0					
Pre-Exposure Prophylaxis	$852,084	5%	6%	88%	0%	
Condom and Lubricant Programming	$1,938,228	51%	49%	0%	0%	
Opioid Substitution Therapy	$19,012	0%	100%	0%	0%	
Primary Prevention of HIV & Sexual Violence	$1,192,144	0%	100%	0%	0%	
Prevention (Not Disaggregated)	$6,449,878	24%	16%	60%	0%	
Socio-economic (incl. OVC)	$16,777,768	0%	21%	79%	0%	
Case Management	$1,073,046	0%	10%	90%	0%	
Economic Strengthening	$2,622,522	0%	0%	100%	0%	
Education Assistance	$3,907,013	0%	0%	100%	0%	
Psychosocial Support	$3,247,800	0%	48%	52%	0%	
Legal, Human Rights, and Protection	$2,054,603	0%	83%	17%	0%	
OVC (Not Disaggregated)	$3,872,784	0%	5%	95%	0%	
Above Site Programs	$9,446,399	13%	32%	55%	0%	
Human Resources for Health	$405,000	0%	0%	100%	0%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$735,000	0%	0%	100%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$3,383,733	24%	33%	42%	0%	
Laboratory Systems Strengthening	$875,000	0%	0%	100%	0%	
Public Financial Management Strengthening	$0					
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$2,454,336	17%	34%	50%	0%	
Laws, Regulations and Policy Environment	$530,000	0%	0%	100%	0%	
Above Site Programs (Not Disaggregated)	$1,063,330	0%	100%	0%	0%	
Program Management	$23,117,374	1%	22%	78%	0%	
Implementation Level	$23,117,374	1%	22%	78%	0%	
Total (incl. Commodities)	**$163,585,893**	**14%**	**19%**	**67%**	**0%**	
Commodities Only	**$25,553,211**	**0%**	**42%**	**58%**	**0%**	
% of Total Budget	*16%*					

*Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available

Table 2.3.2 Investment Profile for HIV Commodities

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2021
Antiretroviral Drugs	$10,951,442	0%	42%	58%	0%	
Laboratory Supplies and Reagents	$5,497,734	0%	32%	68%	0%	
CD4	$0					
Viral Load	$2,840,631	0%	0%	100%	0%	
Other Laboratory Supplies and Reagents	$2,657,103	0%	66%	34%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$1,330,989	0%	8%	92%	0%	
Essential Medicines	$734,494	0%	10%	90%	0%	
Tuberculosis Medicines	$325,696	0%	7%	93%	0%	
Other Medicines	$270,799	0%	6%	94%	0%	
Consumables	$2,742,871	0%	55%	45%	0%	
Condoms and Lubricants	$579,866	0%	100%	0%	0%	
Rapid Test Kits	$2,146,782	0%	43%	57%	0%	
VMMC Kits and Supplies	$0					
Other Consumables	$16,223	0%	100%	0%	0%	
Health Equipment	$1,227,610	0%	100%	0%	0%	
Health Equipment	$979,274	0%	100%	0%	0%	
Service and Maintenance	$248,336	0%	100%	0%	0%	
PSM Costs	$3,802,565	0%	41%	59%	0%	
Total Commodities Only	**$25,553,211**	**0%**	**42%**	**58%**	**0%**	

*Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available

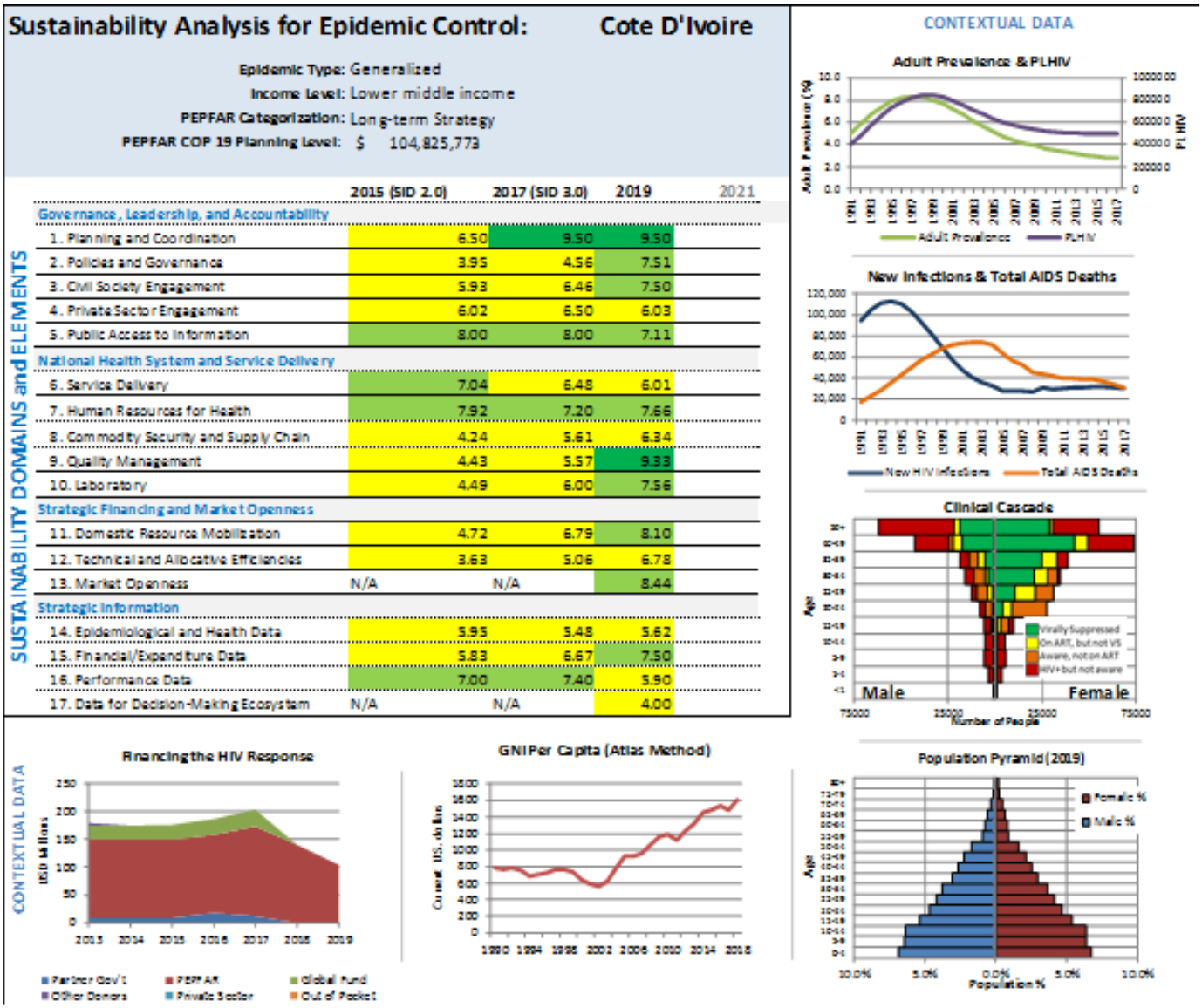
Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Annual USG Non-PEPFAR Funded Investments and Integration (FY21)				
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**
USAID Maternal and Child Health	$5,000,000	$0	0	$0
USAID TB	$0	$0	0	$0
USAID Malaria	$25,000,000	$6,818,298	3	$20,503,037
USAID Family Planning	$7,500,000	$0	0	$0
NIH	$0	$0	0	$0
CDC (Global Health Security)	$0	$0	0	$0
Peace Corps	$0	$0	0	$0
DOD	$0	$0	0	$0
MCC	$0	$0	0	$0
Total	$38,105,773	**$6,818,298**	**3**	**$20,503,037**

2.4 National Sustainability Profile Update

In September 2019, PEPFAR, working in collaboration with UNAIDS and other key stakeholders, completed the 2019 Sustainability Index and Dashboard (SID) and Responsibility Matrix (RM) in collaboration with the MSHP through the Directeur Générale de la Sante (DGS) and PNLS. The participatory process of completing the SID included other partner governments and stakeholders including key GoCI ministries, civil society, private sector and other bilateral and multilateral donors (i.e., GF, World Bank). In general, Côte d'Ivoire has made progress on the majority of the sustainability elements. Despite this notable progress, the program is still struggling in some areas with persistent vulnerabilities. As seen in Figure 2.4.1, these areas of vulnerability include private sector engagement, service delivery, commodity security and supply chain, technical and allocative efficiencies, epidemiological and health data, performance data, and data for decision making ecosystem. In COP20, PEPFAR-CI will focus on several above-site interventions aiming to improve the score for sustainability elements, prioritizing those with low scores. PEPFAR-CI is also collaborating with the MSHP and other health sector donors to continue oversight on sustainability elements with good scores. Similarly, in the Defense sector, the Military Sustainability Index and Dashboard (MILSID) is conducted on a yearly basis, and results guide evidence-based decisions on PEPFAR's above site investments.

Figure2.4.1 Sustainability Index Dashboard



2.5 Alignment of PEPFAR investments geographically to disease burden

Beginning in COP19, PEPFAR investments transitioned from supporting 83 to 60 of the 86 health districts in Côte d'Ivoire where an estimated 90% of the PLHIV are located (Spectrum 2019 and 2020 estimates). In addition to 198 sites[4] in the 23 transitioned districts to MSHP in FY2020, PEPFAR-CI also transitioned an additional 138 low-volume sites[5] to MSHP and ended support to 68 private sites.

[4] Includes the 186 sites identified during COP19 planning and an additional 12 sites that were redistricted into the 23 transitioned districts prior to FY21 (COP19) implementation.

[5] Low volume sites were identified as those having <5 total HTS_TST_POS for FY18 or <10 TX_CURR as of FY19Q1 (December 2018); 138 sites were identified as low-volume during COP19 planning.

In COP20 (FY2021), PEPFAR-CI transitioned an additional 409 low-volume sites[6] to MSHP. As of May 2021, PEPFAR investments support a total of 516 sites, including the military program represented as a single (1) site. In FY2021, PEPFAR-CI updated its geographic hierarchy to align with the redistricting implemented by GoCI in 2020, which redrew health district lines and separated some districts into two or three districts. The result is that there are now 113 health districts total covering the same geographic territory. PEPFAR investments continue to support the same geographic location, now divided into 79 health districts, where 89% of PLHIV are located (Spectrum 2021).

PEPFAR investments will continue in COP21 to support the same geographical area as in COP20 (60 health districts), now represented by 79 health districts following GoCI re-districting where a core package of services will be provided across the 516 PEPFAR-funded ART sites and community catchment areas. Within the 79 health districts, PEPFAR investments will continue to align with PLHIV on ART volume and coverage gaps; critical gaps in the case finding, continuity of treatment, and achievement of pediatric viral load suppression; and where large numbers of KP and other priority populations are served. Direct service delivery and technical assistance approaches will be calibrated to specific performance challenges, patient volume, and sub-population gaps at each site and surrounding catchment area within the constraints of available funding. A detailed articulation of the strategy is found in Section 3.0.

2.6 Stakeholder Engagement

Stakeholder engagement was critical to ensure that continuity of services was maintained for patients on ART. In the setting of COVID-19, PEPFAR partnered with the PNLS and MSHP to accelerate implementation of new policy changes and provided technical assistance to the GoCI in the development of the COVID-19 contingency plan. Stakeholder contribution in the operationalization of the contingency plan ensured that patients' safety remained at the center of the COVID-19 response whilst increased access to essential HIV prevention, care and support was assured. Throughout COP20, COP20 implementation and during the COP21 planning process, PEPFAR-CI engaged and continues to engage many critical stakeholders including: GoCI - Minister of Health, Director General of Health (DGS), and the PNLS; CSOs; and bilateral and multilateral partners such as UNAIDS, WHO, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The PNLS and CSOs have been engaged in the review of COP20 implementation throughout the year during the COVID-19 pandemic, notably through the quarterly and day-long virtual pre- or post-PEPFAR Oversight and Accountability Response Team (POART) meetings organized by the PEPFAR Coordination Office (PCO). Specifically, virtual meetings were organized with CSOs to review recommendations from COP20 around the COVID-19 response and mitigation and ministry sites' adherence to policy changes in light of the pandemic and regarding their oversight of ensuring free and accessible, patient-centered care including accelerated 3 multi-month ARV distribution at

[6] Low volume sites were identified as those having <100 TX_CURR as of FY20Q3 and not serving a critical geographic location or population, including TB patients, FBO, and large proportion of men or children

PEPFAR supported health facilities and community sites. PCO facilitated other preparatory meetings to identify sharing of best practices for quality delivery of HIV services to PLHIV.

Notable examples of Côte d'Ivoire's high-level engagement in the COP21 process include the following:

- In May 2020, PEPFAR, participated and provided critical technical contribution to the development of the National Strategic Plan (NSP) to fight HIV, AIDS, and Sexually Transmitted Infections 2021-2025. Despite the special conditions imposed by the spread in Côte d'Ivoire of the COVID-19 epidemic during the period of March-April 2020, the process of developing the NSP was participatory and inclusive. PEPFAR actively provided technical assistance and worked in collaboration with PNLS, the Global Fund, UNAIDS and other key stakeholders, and with the MSHP through the DGS. The participatory process of completing the NSP included active engagement of the civil society.

- In mid-January and early February 2021, PEPFAR-CI hosted two meetings with CSOs to solicit feedback and discuss progress and challenges with the implementation and oversight of the COVID-19 contingency plan for HIV and uninterrupted service delivery. The meeting also served as a platform to discuss the COP21 virtual planning calendar and expectations. The meetings produced increased advocacy at MSHP level to extend the 3-MMD beyond the contingency period as the policy improved their quality of life by minimizing their frequency to the health facility as well as their risks to COVID-19 infection. After the COP21 planning pause, four additional meetings were conducted with stakeholders in April and May 2021 to review the proposed COP21 strategies, targets and budget proposals as well as solicit and integrate feedback provided into the final strategic plan for the next fiscal year.

- After the multisectoral dialogue organized in January 2020 by the Country Coordinating Mechanism (CCM)-Cote d'Ivoire, another meeting was organized in May 2020 with stakeholders involved in the fight against AIDS, Tuberculosis and Malaria to participate in the development of the GF New Funding Mechanism (NMF-3) 2021-2023. Stakeholders including the civil society actively engaged in providing contribution to effective use of GF resources to support solutions to maximize the impact achieved and to examine how all available resources will be maximized in the most efficient way to consider the needs of PLHIV in Cote d'Ivoire and serve the country's objectives. In this context and to ensure the continuity of the efforts and the sustainability of the achievements, the GF announced on December 16, 2019, the amount allocated to Côte d'Ivoire for the 2021-2023 cycle. The table below highlights Global Fund Investments for 2021-2023.

Table 2.6.1: Summary of Global Fund Investments for 2020-2022

Diseases	Allocation	Allocation Utilization Period
HIV	$89,652,900	1 January 2021 to 31 December 2023
Tuberculosis	$18,449,500	1 January 2021 to 31 December 2023
Malaria	$143,440,000	1 January 2021 to 31 December 2023

Total	$251,542,000

Exchange Rate: May 2021 (€1 to $1.21344)

During the implementation of NFM3 between 2021-2023, the GF will focus its investments on reducing incidence and scaling-up effective prevention efforts, and in strengthening both health and community systems. It will also prioritize its investments with key and vulnerable populations and ensure that human rights-related barriers to health and gender inequalities are addressed. Successes achieved will need to be sustained including working in collaboration with other stakeholders to mobilize increased national resources for health. The funding requests submitted were aligned with prioritized country needs and guided by relevant National Strategic Plans and program reviews. For the HIV funding request, government and all actors involved in the fight against HIV are currently working towards achieving epidemic control. To improve retention in care and address the challenge of loss to follow up especially during the COVID-19 pandemic, the GF continues to advocate for policy and programmatic changes to facilitate community dispensation of antiretroviral (ARV) drugs including 3MMD and 6MMD, and to scale up TLD. Investments will also support strengthening health and community systems that are essential to accelerating progress toward epidemic control, removing human rights and gender-related barriers in access to services, and increasing domestic resources for health -- specifically for HIV, tuberculosis, and malaria, which are essential to ending the epidemics and strengthening the health systems that are the foundation of the disease response.

- On May 17, 2021, the Minister of Health, the DGS and the U.S. Ambassador will participate in the COP21 approval meeting in Abidjan, Côte d'Ivoire.

The stakeholder engagement calendar below provides a detailed overview of how PEPFAR-CI engaged these stakeholders and involved them in the development of COP21. Since January 2021, many activities were carried out remotely via phone or email in light of the ongoing COVID-19 pandemic.

Table 2.6.2 PEPFAR-CI COP Activities

Date	Objective	Outcomes	Next steps	Comments
Before COP21 Submission				

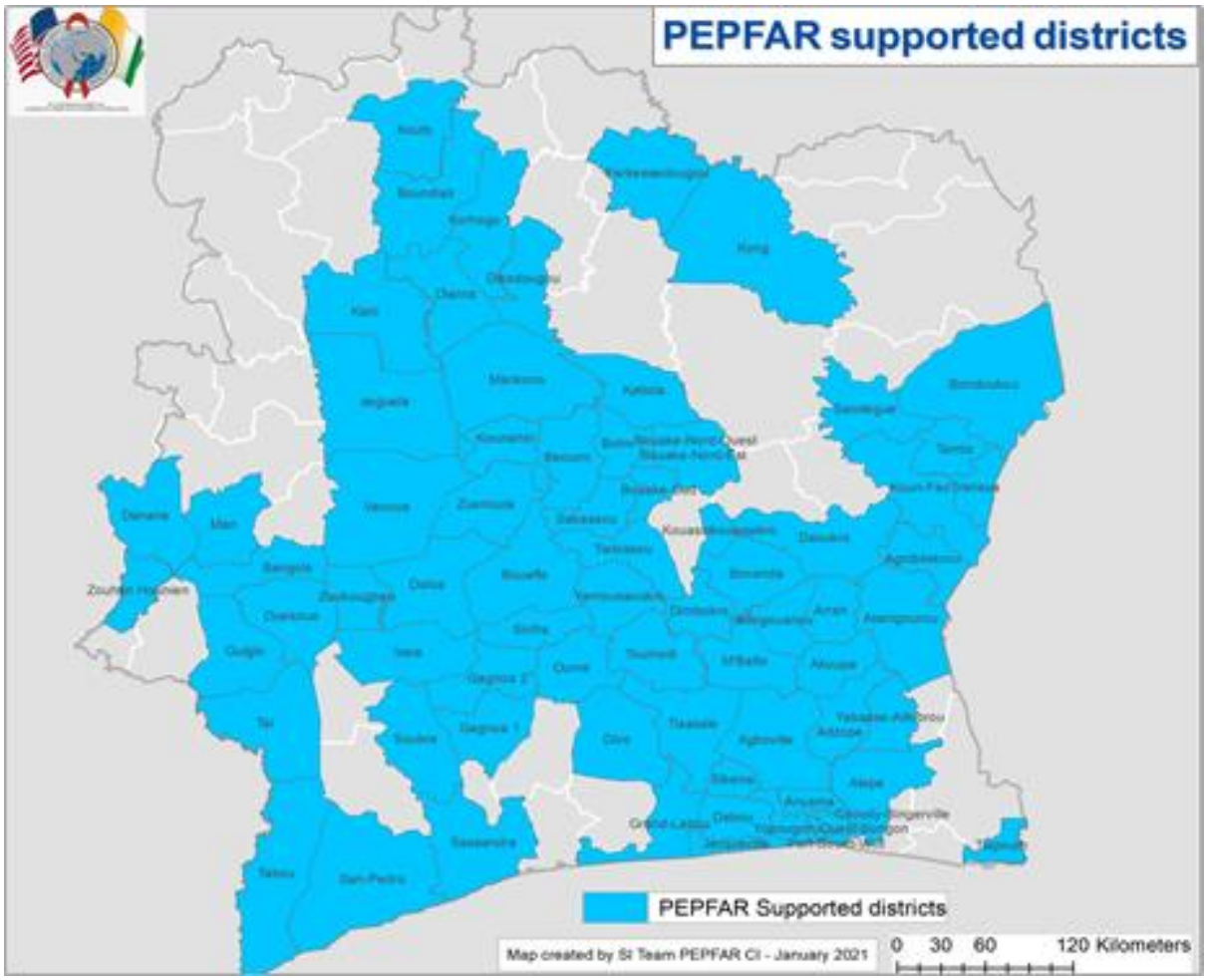
Date	Objective	Outcomes	Next steps	Comments
01/14/2021	PEPFAR-CI shared with stakeholders: The COP21 development process, the PLL COP21 overview	Stakeholders understand the COP process. Stakeholders understand the timeline for the next steps of the COP21.	Plan the next meeting. Share the documentation.	Meeting was held virtually and led by PCO
01/28/2021	Stakeholder Meetings COP19 APR/COP20Q1 results review With participation of: CSO; WHO, IPs, UNAIDS, GF, PNLS and all DDs (district directors)	Opportunity for PEPFAR IPs to share achievement /challenges and way moving forward (from Q1) to improve performance and fix issues related to retention, TPT for all, TLD transition for all (incl. women of childbearing age), and other WHO recommendations in presence of all stakeholders and the MSHP to improve in-country ownership	Virtual meetings were co-facilitated by PEPFAR and MSHP to review all IPs achievement CSOs representatives to participate and report any issues found at the site/community level	
01/29/2021 In –Country virtual retreat	Discuss COP21 guidance /orientation COP21 expectations from stakeholders, timelines for future steps Receive input from stakeholders on the COP21 strategy for CI.	Stakeholder feedback was shared	Continue discussion via phone and email to ensure stakeholder inputs are considered for, especially the need to support CSO watchdogs' activities and stigma/discrimination intervention	
04/02/2020	Phone call with stakeholders to discuss impact of COVID-19 on HIV patients, PNLS contingency plan for treatment and communication plan for disseminating information to PLHIV			The GF, UNAIDS, PEPFAR and PNLS participated in this remote meeting to ensure that revised treatment options were made available considering COVID-19 (MMD, TLD and VL)
04/09/2021	Review of COP21 strategy by program area and solicit feedback for PEPFAR Meeting was led by PEPFAR interagency	Virtual meeting was held with CSO to review the COP21 proposed strategies by program area	CSO members reviewed the proposed strategies and prepared responses	Draft strategic plans were shared via email to CSO
04/12/2021	Meeting to receive feedback from the CSO on proposed strategic direction of the program for COP21 Meeting was led by PEPFAR interagency with participation from SGAC Chair and PPM	Virtual meeting was held with CSO to receive feedback on the COP21 proposed strategies by program area and specific plea for CSO engagement in the program implementation	PEPFAR interagency team to integrate feedback from CSO in the subsequent revisions of the strategic plan and COP21 proposal	Feedback was received during the discussions and via email

Date	Objective	Outcomes	Next steps	Comments
04/24/2021	Summary of Draft revised COP21 proposal (DataPack summary, FAST and strategic vision) shared with stakeholders	Virtual meeting was held with civil society members to review the flat packs for FAST and DataPack and address any concerns ahead of the virtual COP21 planning meeting		Draft flat packs were shared via email with CSO and all stakeholders (Documents were in French and English). Feedback solicited via email given the COVID-19 pandemic
4/26-4/27, 2021	COP21 virtual planning meeting Meeting was led by SGAC with participation from stakeholders including the MSHP, PNLS and multilateral stakeholders	Stakeholders participated in person and virtually in the virtual planning meeting		
05/04/2021	Meeting held with CSO to review the continuous quality improvement program and expectations for CSO engagement in advocating for immediate resolutions to data quality and data integrity issues affecting program performance at site and community levels Meeting was led by PEPFAR (HRSA)	CSO provided feedback on how to actively engage in program implementation and hold PEPFAR accountable for ensuring ethical practices of IPs for managing patient data and working toward achieving targets		
05/07/2021	Draft COP21 SDS shared with stakeholders and meeting held with CSOs to review feedback integrated in the budget and DataPack	Meeting with CSOs was conducted virtually and led by PCO		Draft SDS was shared via email with CSO and all stakeholders (English version)
06/01/2021	Final SDS to be shared with CSOs and other stakeholders			
After COP21 Submission				
06/05/2021	PEPFAR-CI to explain how stakeholder feedback was incorporated in COP21 planning and how PEPFAR will continue to engage them throughout the year	Stakeholders understand how PEPFAR will continue to engage with them throughout the year and what feedback was incorporated into COP21, what was not, and why these decisions were made.	Share the redacted COP21 when available and approved.	A redacted version of the approved COP21 will be shared by email. Hard copies will be available upon request.

3.0 Geographic and Population Prioritization

PEPFAR-CI prioritizes investments, both geographically and demographically, to achieve 95:95:95 and reach epidemic control. In COP21, PEPFAR-CI will continue to support clinical service delivery and community services in 79 of 113-health districts in Côte d'Ivoire (see Figure 3.1.1 for a map of the 79 districts). These 79 districts are prioritized for targeted PEPFAR programming to higher-risk populations with 89% of the national PLHIV burden (see Table 3.1.1 for the current status of ART saturation in these districts).

Figure 3.1.1 COP19, COP20 & COP21 PEPFAR geographic presence



PEPFAR-CI used the updated UNAIDS PLHIV and small area estimates (2021), including input from the CIPHIA results (2018), updated ANC surveillance survey (2020), and population estimates (2021), to assess ART coverage gaps at the district level. Seventeen (17) health districts have met the second 95 target: Treichville-Marcory (117%), Bouake-Nord-Ouest (109%), Bouake-Sud (107%), Tanda (106%), Yamoussoukro (105%), Ferkessedougou (105%), Bondoukou (105%), Akoupe (104%), Katiola (102%), Sakassou (102%), Yopougon-Ouest-Songon (98%), Arrah (97%), Korhogo 1 (97%), Koun-Fao (97%), Dimbokro (96%), Gagnoa 1 (95%), and Abengourou (92%). Another 19 health districts have met the second 90 target.

When assessing ART coverage by subpopulation, a total of 24 districts have achieved the second 95 among women. Only Bouake-Nord-Ouest and Tanda have achieved more than 90% ART

coverage among children (<15), men and women. PEPFAR-CI anticipates achieving the second 90 treatment saturation (81% ART coverage) in 50 districts and the second 95 (90% ART coverage) in 23 of those districts by the end of FY2022.

To achieve the 95:95:95 targets, the PEPFAR-CI program is continuing to intensify targeted case finding and rapid ART enrollment strategies for prioritized districts and populations. Despite direct service delivery already being the dominant program implementation approach, implementing partners (IPs) will continue to adapt, target and refine their remaining technical assistance (TA) and coaching approaches with the goal of further increasing their site-level presence and direct support (including HRH), particularly at prioritized low-performing sites with the capacity for significantly higher volume. Site level and district-level data from FY21 Q1 show improvement in linkage and continuity of treatment as well as continued scaling of index testing, PEPFAR-CI is continuing to direct its IPs through intensive oversight to continue to prevent interruptions in treatment and improve linkage at sites (see Section 4 for detailed description of activities). PEPFAR-CI also continues to use site-level performance, to target COP21 investments and focus key interventions to address population-specific gaps in prioritized tiers of sites that represent those with the greatest need and opportunity for greatest impact (see below for an explanation of site-level prioritization and alignment of investments). Table 3.1.1. shows the current status of ART saturation and progress towards 95-95-95 across all 79-PEPFAR-supported health districts.

Table 3.1.1 Current Status of ART saturation

Current Status of ART Saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP21**	**# Current on ART (FY21 est)**	**# of SNU COP20 (FY21)[2]**	**# of SNU COP21 (FY22)**
Attained				
Scale-up Saturation	**89%** 330,560 / 370,676 national PLHIV est.	268,799[1]	79	79
Scale-up Aggressive				
Sustained				
Central Support				
Not PEPFAR Supported	**11%** 40,116 / 370,676 national PLHIV est.	26,709	35	35

1. Results include sites that are not PEPFAR supported with Scale-Up Saturation SNUs.

2. In COP20 (FY21), PEPFAR-CI updated its geographic hierarchy to align with the redistricting implemented by GoCI that redrew district lines and separated some districts into two or three districts. The result is that there are more districts (prioritized SNUs) than previous years, but they cover the same geographic territory.

To reach ART saturation, as mentioned in Section 2.5 above, PEPFAR-CI will provide tailored packages of both clinical and community services to different sites and populations based on needs and gaps.

Clinic-based Support

In COP21, a core package of services will continue to be provided across all PEPFAR-funded sites following the same site-tiering scheme used in COP20. In addition, COP21 will continue to align additional HRH investments at the facility level (ART site) based upon site-specific needs as follows:

- **High impact: 173 ART sites, including military PSNU, representing 67% of TX_CURR (FY21Q1)**
  Continuity of treatment for these sites remain unchanged from COP20. Sites will receive PEPFAR's core package of services in addition to increased human resources for health (HRH) investments calibrated based on performance, needs, and gaps to strengthen targeted testing, scale-up of index testing, and adherence/ continuity of treatment support to prevent interruption in treatment (IIT) and achieve program goals and COP21 targets. Facility-based HRH investments will consider existing community-based cadres (and vice versa) to maximize efficiency in activities including defaulter tracing, adherence and continuity of treatment support, and patient return to care. To ensure investments are as efficient as possible, there will be clearly defined and distinct roles and responsibilities for facility and community-based HRH staff. In the military program, HRH investments will continue supporting the military health system to address the gaps due to the proportion of military HRH leaving the Ministry of Defense (MOD) under its early retirement policy, and the positions that are scarcely provided by the MOD such as social or community actors.

- **Moderate impact sites: 282 ART sites representing 24% of TX_CURR (FY21Q1)**
  Moderate impact sites also remain unchanged from COP20 and include sites located primarily outside of Abidjan (234 of 282 sites are not in one of two Abidjan regions). Based on volume and gaps in case finding, continuity of treatment and VLS, some moderate impact sites will receive additional HRH investments, including a lay worker at the site and a social worker, data clerk, and data manager based at the district level. As mentioned above, facility-based HRH investments will be calibrated based on community-based cadres and roles and responsibilities will be clearly defined and distinct. The remainder of moderate impact sites will receive support through a Technical Assistance-Service Delivery Improvement (TA-SDI) approach in coordination with MSHP support and supervision. Sites receiving the TA-SDI approach will receive PEPFAR's core package of services and be supported by IPs through quarterly mentorship and supervisory support for core services across clinical cascade, differentiated service delivery, and lab sample transportation. Sites will report results as a TA-SDI site as defined in the PEPFAR Monitoring, Evaluation, and Reporting (MER) guidance.

  Together high and moderate impact sites include a total of 455 ART sites and the military PSNU, accounting for more than 90% of TX_CURR (FY20Q1 results)

- **Low impact: 61 ART sites representing <10% of TX_CURR (FY21Q1)**
  Following the transition of 409 low volume sites to MSHP at the beginning of COP20, only 61 sites were retained as low impact sites receiving PEPFAR support. These sites would be maintained in COP21. Support will include the core package of services through a TA-SDI approach: sites will receive quarterly visits for mentorship and will report results as defined in the PEPFAR MER guidance.

Community-based Support

Community-based support for case finding, adherence/continuity of treatment, and viral load suppression will be provided through differentiated packages of services at the community-level based on targets and population profiles demonstrating the greatest needs at the district-level and interpolated to commune/catchment areas of PEPFAR support. Community support will be aligned with sites that have concentrated gaps in case finding, continuity of treatment, and VLS among prioritized populations. Population profiles include age and sex disaggregation for case finding among hard-to-reach sub-populations and sub-groups of PLHIV (such as those who are new on treatment, have suffered treatment interruption, and/or who are viremic) for tailored care and support. To ensure investments are as efficient as possible, there will be clearly defined and distinct roles and responsibilities for facility and community-based HRH staff.

As most of the low impact sites have transitioned to MSHP support, no additional PEPFAR investments in general community programming are expected in their catchment areas. Since 2017, the MSHP has adopted differentiated service delivery model[7] (DSDM) policy as part of the standard care package for patients on ART that is being scale up at all sites. In February 2020, this package was expanded to include community ARV distribution. In COP19, the PNLS, the Direction of Community Health (DSCMP) in collaboration with donors and implementing partners are developing the models, procedures, monitoring tools and materials to the implementation of community ARV distribution at a small scale. Community ART implementation has accelerated in light of the COVID-19 pandemic beginning in March 2020. In low HIV burden districts/low volume ART sites, including the majority of low impact sites that are transitioned to MSHP, they will use community health agents (ASC) who are traditionally engaged in health promotion/prevention activities, including bed-net distribution, immunization campaigns, maternal, neonatal and child health (MNCH), and directly observed of tuberculosis (DOT) treatment to also distribute ARVs as part of a comprehensive package. Community health agents are selected by their own community members with the approval of the health district director and are directly supervised by nurses and/or midwives of the heath care center they are attached to. This will be the way forward to sustain this activity with country ownership.

OVC programming will continue to work in 38 of the 79 PEPFAR-supported districts (selection made in COP18 based on volume of PLHIV), KP programming will focus on 42 districts plus the military program based on KP population density and hot-spots, and DREAMS will remain in the same 4 districts, working towards saturation. Population-specific programming materials

[7] Cote d'Ivoire Ministère de la Santé et de l'Hygiene Publique, Note Circulaire, Fevrier 2017

will be shared with MSHP, who may pursue expansion of these programs, such as DREAMS programming, to other districts.

Additional details on the packages of services to be provided are provided in Section 4. See also Figure 3.1 for COP21 PEPFAR geographic presence.

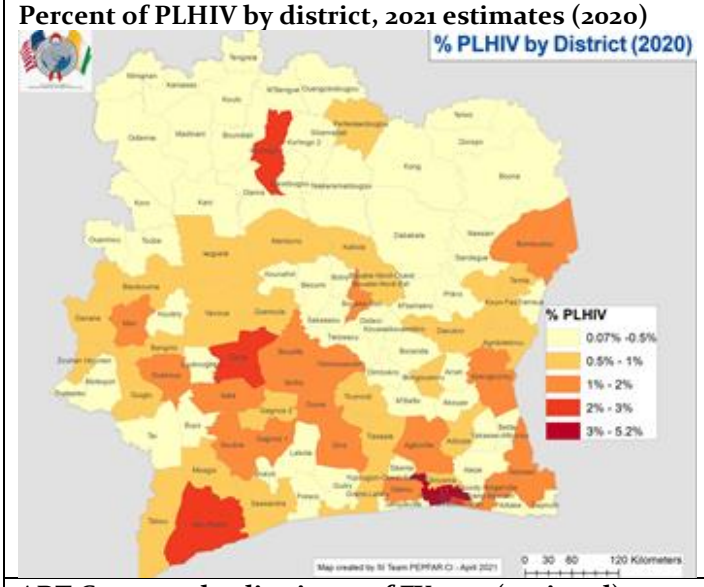
Table 3.1.2 Clinical/Community based Investments

Types of Sites	Number of Sites	HRH	Supervisory Visits	Laboratory Sample Transport	Patient-centered Quality Care Support	Other Support (materials etc.)
High Impact	173 (includes military program)	Social workers, Facility lay workers, data clerks and data managers based at site	Monthly	Provided	Targeted case finding through PITC, facility and community safe index testing, community mobile outreach; Community ART; Multi-month dispensing; continuous quality improvement (CQI) activities; Differentiated adherence/continuity of treatment support; Community-level promotion of HIV literacy and stigma reduction	Training, supplies, equipment, etc.
Moderate Impact: Direct Service Delivery (DSD)	282	Lay worker assigned to the site; social workers, data clerks and data manager assigned to the district	Monthly	Provided	Targeted case finding through PITC, facility and community safe and ethical index testing, community mobile outreach; Community ART; Multi-month dispensing; continuous quality improvement (CQI) activities; adherence/ Differentiated continuity of treatment/adherence support; Community-level promotion of HIV literacy and stigma reduction	Training, minimal supplies, and equipment
Moderate Impact TA-SDI		No PEPFAR staff at sites and PEPFAR district-based staff are not assigned to these sites	Quarterly	Provided	Targeted case finding through PITC, facility and community index testing, community mobile outreach; Community ART; Multi-month dispensing; continuous quality improvement (CQI) activities; Differentiated adherence/continuity of treatment support; Community-level promotion of HIV literacy and stigma reduction	Training
Low Impact	61	No PEPFAR staff at sites and PEPFAR district-based staff are not assigned to these sites	Quarterly	Provided	Targeted case finding through PITC, facility index testing, Community ART; Multi-month dispensing; continuous quality improvement (CQI) activities; Differentiated adherence/continuity of treatment support; Community-level promotion of HIV literacy and stigma reduction	Training

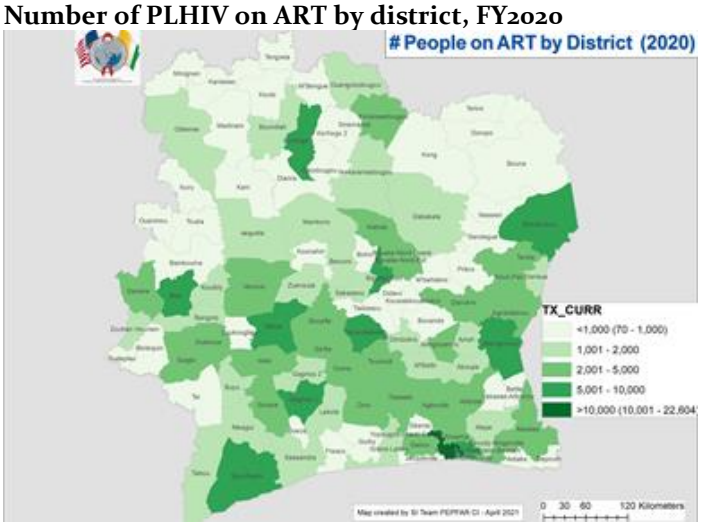
Figure 3.1.2 below shows the current HIV prevalence, ART treatment coverage and viral load testing coverage by district.

Figure 3.1.2 HIV Prevalence, Treatment Coverage and Viral Load Testing Coverage

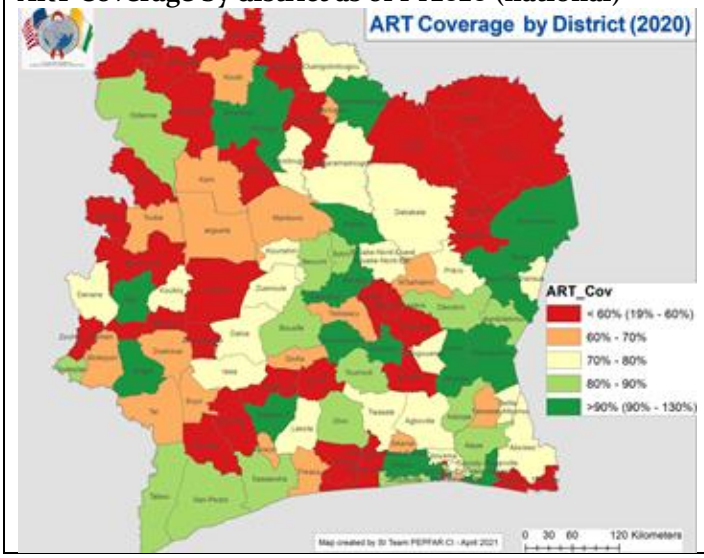
Percent of PLHIV by district, 2021 estimates (2020)



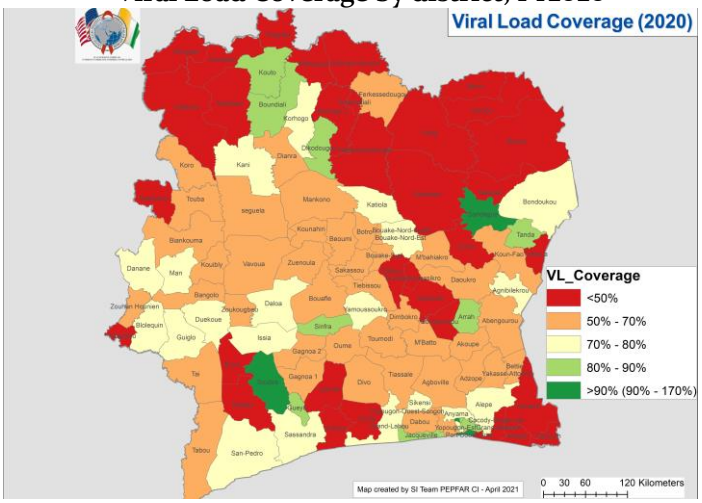
Number of PLHIV on ART by district, FY2020



ART Coverage by district as of FY2020 (national)



Viral Load Coverage by district, FY2020



4.0 Client-Centered Program Activities for Epidemic Control

4.1 Finding the missing and getting them on treatment

PEPFAR-CI aims to treat 276,300 PLHIV by the end of FY2022. In order to achieve epidemic control, PEPFAR-CI is centering its efforts in 173 high impact sites, including military PSNU, representing 67% of TX_CURR (FY20Q1). Those prioritized sites constitute the high impact sites among the 516 ART sites supported by PEPFAR located in 79 districts covering ~70% of PLHIV in Côte d'Ivoire.

Table 4.1.1 below provides details on the core package of services that will be provided to all sites.

Table 4.1.1: COP21 Core Package of Services

Undiagnosed	Newly on Treatment	IIT/Defaulters
• Facility and community safe and ethical index testing with fidelity • Targeted facility based PITC • EID • Universal testing for malnourished and hospitalized children • Targeted community mobile outreach testing for hard-to-reach populations (men and KP) • OVC testing • Prevention support/PrEP (HIV-ve)	• Post-test counseling and preparation for treatment. • Treatment literacy (U=U) initiation support • Appointment reminders • Treatment initiation (TLD/DTG optimization) • Preparation for MMD • Pediatric and adolescent support package of services (disclosure support) • Adult treatment supporters • Peer support groups • VL monitoring/VL champions • Mother-infant pair visits, OVC referrals • TB Tx or TPT/Advanced disease package • STI screening/treatment	• Appointment reminders • Facility-community tracking/tracing and regular review of results • Weekly data monitoring • Treatment coaching/VL monitoring • Identification of a Lay Health Worker responsible for the management of the appointments at sites. • Improvement in documentation of socio-demographic and contact information in patient charts with recurring updates. • Alignment of Viral Load and ARV pick up appointments • Targeted home visits for handing over ARVs in the community for patients who are unable to come to the facility within a week of a missed ARV pickup appointment. • Standardization in implementation and documentation of steps taken to track and return

		patients who interrupt treatment. • Addressing reasons for defaulting/stopping ART • Documentation of transfer-out • Mother-infant pair visits, OVC referrals • TB Tx or TPT Advanced disease package
Not Linked	**Already on Treatment**	**Unsuppressed VL**
• Escort newly tested positive for ART initiation • Treatment literacy (U=U) • Patient tracking and navigation • ART readiness assessment • Linkage facilitator • Case management • Psychosocial support • Appointment management	• Treatment literacy (U=U)/adherence counseling and ongoing support • VL monitoring/VL champions • Differentiated service delivery models, including MMD, community ART refill/pickup • TLD/DTG-based regimen optimization with a focus on women • TB Tx or TPT/Advanced disease package • STI screening/treatment	• Enhanced adherence counselling and repeat VL monitoring • Appointment reminders • ART optimization • Pediatric and adolescent support groups/package of services • TB Tx or TPT/Advanced disease packageAssessment of clients who fail to attain viral load suppression after 3 EAC sessions to determine and address root causes

4.1.1. General approaches

Direct Service Delivery approaches to be continued in FY2022

A key barrier in Côte d'Ivoire HIV/AIDS response is the limited capacity to consistently deliver core clinical services at an optimal standard of care. The focus of PEPFAR's facility-based service delivery support will be to complement MSHP clinicians with lay workers and social workers dedicated to addressing critical programmatic gaps. This will include dedicated personnel to ensure high-quality, patient-centered index testing, monitoring and case management of the pediatric ART cohort, support to caregivers for pediatric ART administration, viral load monitoring, integrated services to improve case-finding among men, and increase PrEP uptake.

PEPFAR-CI, with mutual agreement from the MSHP paused generalized HIV testing and limited this service at the facility level for asymptomatic clients and at the community level in FY19Q3 through FY20Q1, except for index testing and the prevention of mother to child transmission (PMTCT), orphans and vulnerable children (OVC), DREAMS, pre-exposure prophylaxis (PrEP) and key populations (KP) programs. In COP21, community mobile HTS will be targeted to sub-populations based upon gaps in specific SNUs. PITC will be targeted to improve case finding, to include patients presenting with STIs, TB, and those on inpatient or malnutrition services. In

addition, PEPFAR will work closely with MSHP and CSOs to monitor the full implementation of the new national guidelines on the implementation of TLD, monitor the ban on user fees, and the implementation of differentiated models of service delivery including multi-month dispensing of ARVs. PEPFAR-CI will continue to work with the MSHP on a more detailed community ART strategy that outlines: i) service packages, ii) roles and responsibilities of facility-based versus community care providers, iii) human and financial resource allocations to address the needs of specific sites and sub-populations, and iv) a monitoring plan.

Strong collaboration and consultation with GoCI, international stakeholders, and professional associations will be critical in continuously reassessing the most efficient model for PEPFAR support, and to design an appropriate transition plan for sustainability and build on successes to achieve and maintain epidemic control. PEPFAR-CI will achieve this through monthly and quarterly meetings, under DGS leadership, with all stakeholders involved in the HIV response and through joint monitoring of the COP process.

Quality Management

Continuous quality improvement (CQI) and quality management (QM) are critical for improving service quality at underperforming sites with real time course correction. PEPFAR provide support for quality at all levels of the health system, building QM capacity at the national, district, facility, and community levels that is responsive to identified data gaps. The ultimate success of this strategy will require engagement of IPs and provision of value-added support beyond their activities, strong MOH leadership, and an integrated clinical-community approach. Details on this intervention are discussed in Section 4.2 below.

Targeted SIMS visits will be conducted at high impact sites to improve service delivery, and above site level visits will ensure that implementing partners, district health management teams and other central and decentralized entities have the capacity to provide effective support to sites. Facility and community site level data will be collected and aggregated to produce regional and national benchmarking reports. Selected granular site management (GSM) visits will also be conducted by PEPFAR-CI to ensure that new guidelines and technical recommendations are implemented appropriately.

Select moderate impact sites will be monitored by PEPFAR-CI team in collaboration with MSHP through quarterly monitoring of key indicators and will receive GSM and SIMs visits on performance reviews and gaps. At sites prioritized for DSD (direct-service delivery) support, IP staff will conduct periodic coaching visits and site assessments and send monthly reports on key indicators to PEPFAR-CI team.

Low-impact sites will be monitored in accordance with MER guidance for sites receiving TA-SDI support. IP staff will conduct quarterly coaching visits and send quarterly reports on MER indicators to PEPFAR-CI team.

Partner Management

PEPFAR-CI partner management is done at three levels: (i) Activity Managers (AM) will conduct weekly and monthly progress reviews and course correction of deficiencies, in addition to monthly and quarterly partner meetings and financial reviews; (ii) the Interagency team will conduct site visits (frequency to be determined based upon site-specific needs) and data review of key indicators on a monthly basis; and (iii) the National Program will conduct quarterly program results reviews led by the PNLS with the participation of PEPFAR-CI, IPs, and stakeholders. Continued engagement with all stakeholders, including civil society and community members, multilateral partners and bilateral partners, is to continue throughout COP 2021 implementation. Core to this critical engagement is the sharing of and discussion surrounding quarterly results and achievement and findings from community-led monitoring. This continued engagement will ensure all parties' understanding of Côte d'Ivoire's progress and help identify any strategic changes to be made in order to more efficiently and effectively reach epidemic control.

Agreements made during COP21 discussions, including those regarding geographic focus, targets, budgets, SIMS, use of pipeline, partner implementation and partner management will be monitored and evaluated on a regular basis via both ad hoc check-ins and discussions as well as the joint HQ and country team POART discussions. It is expected that teams closely monitor partner performance and engage with each implementing partner on a regular basis to ensure achievement of targets, outcomes and impact in a manner consistent with this memo, approved SDS, and budgets and targets as finalized in PEPFAR systems. Any partner with EITHER (1) <15 percent of target achievement at 3 months or (2) less than 40 percent of target achievement at 6 months must have a complete review of performance data (including trends in performance) and expenditures to date by program area, implement remediation, and conduct intensive follow-up. Biannual data reporting is acceptable for programs that do not report on a quarterly basis (e.g. OVC program). In the HIV treatment program, most clients are continuing on treatment year after year and current on treatment (TX_CURR) performance should be between 98 percent and 100 percent of the target. This can be adjusted in country context where HIV treatment services are still scaling up and the treatment new target is greater than 10 percent of treatment current. OVC programs are also similar in that there are clients continuing services from the previous year; if the IP is less than 80 percent of their target at Q2 performance review should be triggered.

For key populations programming, per MER Guidance and program requirements, HIV testing is a required element of the KP_PREV indicator. HIV testing services (HTS) or referring an

individual to HTS is required to be offered (at least once during the reporting period and/or in accordance with WHO/national guidance) unless the individual had previously been tested positive for HIV. HIV prevention services must be tailored to individual risks. If the individual is self-identified as HIV positive, then HTS provision or referral to HTS will not be a required element of this indicator. Workplans for IPs should reflect these HTS requirements for key populations programming. Additionally, where referral to HTS is made, IP workplans and program design should incorporate measures to follow through on HTS with KP clients to ensure referral completion. These elements (i.e. review, remediation, and follow-up) should be incorporated into the existing IP work plans. A second quarter of consistently poor performance by the IP should also result in implementation of a documented Performance Improvement Plan (PIP) or Correction Action Plan (CAP), in accordance with implementing agency policy. PIP indicators should reflect the core issue. If the issue is linkage of test positive to treatment the indicator measured should be test positive to new in treatment of greater than 85 percent. If the issue is retention it should be net new on treatment equal to 90 percent of new on treatment. After two quarters of intensive oversight and remediation for underperformance, partners should be close to full achievement of targets expected at quarter three. With a third quarter of consistently poor performance by the IP, implementing agencies should notify S/GAC the options the agency is implementing to address partner non-performance. including options for a shift to new partners. The country team should notify the S/GAC Chair and PPM immediately of the improvement plan.

Community-Facility Linkage

Strengthening community and facility collaboration is a critical component of PEPFAR-CI's strategy to increase case finding and linkage to ART and retain patients on treatment. Starting in COP19, PEPFAR-CI rationalized the geographic distribution of clinical and community partners, limiting the number of partners intervening in one region and pairing each clinical IP with a community IP [8] to increase efficiency. Memoranda of understandings (MOUs) were created to formalize this collaboration, delineating roles and responsibilities of each partner in upholding services across the clinical cascade starting in Q4 of FY2019 and into FY2020. PEPFAR-CI will continue to review existing MOUs and monitor benchmarks of success in addressing coverage gaps across populations and age bands on a quarterly basis. Each IP will have a clear scope of work and standard operating procedures (SOPs) for monthly tracking of

[8] For USAID the main community partner is Breakthrough-ACTION (BA) that serves as the interface with the facility representing the consortium of USAID specialized partners (including OVC/DREAMS and KP as well as the general population covered through BA).

referrals/counter-referrals and patients with interruption in treatment (IIT) who have been found in the community and returned to a health facility to continue treatment. During COP20, and continuing into COP21, this data will be analyzed by the interagency PEPFAR-CI team, in order to quickly identify areas where coordination and data sharing among IPs need improvement. The MSHP national referral and counter-referral tool will continue to be used to facilitate consistent tracking of patients, along with the scale-up of CommCare, a tablet-based, patient-level data management system which spans both community and facility. Scale-up of this tool will be critical to help address ongoing challenges in data quality and integrity regarding linkage to treatment of individuals testing positive in the community.

Community IPs are responsible for the following community interventions based on the clinical-community MOU operationalized algorithm:

(1) case finding in the community including index and targeted mobile testing (2) provision and follow-up of self-test kits (assisted or home-based), (3) active referral for ART initiation for those identified in the community to increase treatment coverage and reduce mortality, (4) Reinforced adherence counseling for ART patients (5) Community ART distribution, (6) implementation of differentiated care models, (7) establishing and implementing support groups including "patient buddy systems" (8) screening for opportunistic infections such as TB and active referral for treatment, and (9) home visit tracking of PLHIV who are lost to follow-up, and identifying barriers to seeking treatment and reasons for interruption in treatment. This community-to-facility bidirectional referral is critical to keep clients engaged across the continuum of care. Clinical IPs will provide intensified support to specific sub-populations to prevent IIT, thereby reducing the need for community-based defaulter tracking. For the ART patients demonstrating challenges, facility- and community-based models of care and support will be offered as options for optimal patient-centered care. Clinical IPs will make referrals to community IPs for support services to improve adherence and VLS, as appropriate. Community and clinical IP work plans will reflect their synergistic roles in client care. Use of the community-facility matrix, introduced in COP19, and used at scale in COP20, will continue in COP21 to further strengthen the monitoring of the community-facility collaboration and the dyad's shared results.

Strengthening clinical-community collaboration will facilitate a smooth continuum of care for patients and support full implementation of differentiated service delivery models, including 6-MMD and/or community ART for stable patients; through this differentiation, stable patients will receive an increasingly "lighter touch" from the health system overall. To ensure that these

patients remain connected to care, peer support groups would be established at PEPFAR-supported sites where they do not already exist, and strengthened at sites where they already do, and participation by all patients would be encouraged. PLHIV identified in the community are referred and escorted by community counselors or peers to the facility for same day ART initiation. In the context of index case testing and partner notification, counselors and providers ensure that a gender-based violence risk assessment is completed, and that contact elicitation is carried out according to Safe and Ethical Index Testing Guidance and standards. All biological children < 19 years old of individuals newly diagnosed with HIV, will be offered testing for HIV, in a manner consistent with PEPFAR Guidance on Implementing Safe and Ethical Index Testing. Also, HIV-infected children and exposed infants are linked with OVC platforms as priority beneficiaries.

Lay worker counselors from the facility and the community will hold weekly coordination meetings to ensure that referred patients received same day or prompt ART initiation, patients who have interrupted treatment are tracked and traced, transfers out are documented, and patients' social needs are addressed promptly. Monthly multidisciplinary team meetings at sites and quarterly district coordination meetings will be reinforced to ensure effective partnership and outcomes as well as good linkage between community and clinical settings. The CommCare tool will facilitate patient-level tracking across both facility and clinical IPs, and dashboards will illustrate patient-level data on linkage, TLD uptake, missed appointments and opportunities to intervene to reduce or address treatment interruption.

Human Resources for Health (HRH)

HRH shortages are a significant barrier to high-quality service delivery required for HIV epidemic control. Specific challenges include: (i) lack of an accurate assessment of the total number of health providers required to provide HIV/AIDS services and other basic health services; (ii) MSHP and Ministry of Defense (MoD) budgetary constraints limiting the recruitment of sufficient staff; (iii) the imbalanced distribution of health care workers across the country; (iv) demotivated MSHP and MoD health care providers overwhelmed by HIV service delivery and data collection; (v) outdated attitudes promoting blanket (rather than targeted) provider-initiated testing and counseling (PITC); and (vi) the recent significant reduction in military health providers because of an early retirement policy implemented in 2019, (vii) the persistent problem of health care workers leaving public facilities during working hours to treat private patients off-site.

Currently, significant efforts are being made to use a data driven approach in determining and monitoring HRH requirements, allocation, performance, and productivity to support HIV targets achievements, the roll-out of key policies, and patient centered services. Steps have been taken to ascertain the number and categories of health care workers required at sites and the distribution of health care workers across the country. At the end of COP20, SGAC will roll-out a human resource information system (HRIS) to track PEPFAR staff down to the facility and community level to ensure budget allocations for HRH align with expenditures. In COP21, this HRIS will be utilized to ensure adequate staffing at facilities and at the community level. Facility level HRH investments will consider existing community-based cadres to maximize efficiency in activities including defaulter tracing, adherence and continuity of treatment support, and patient return to care. To ensure investments are as effective and efficient as possible, there will be clearly defined, distinct, and coordinated roles and responsibilities for facility and community-based HRH staff.

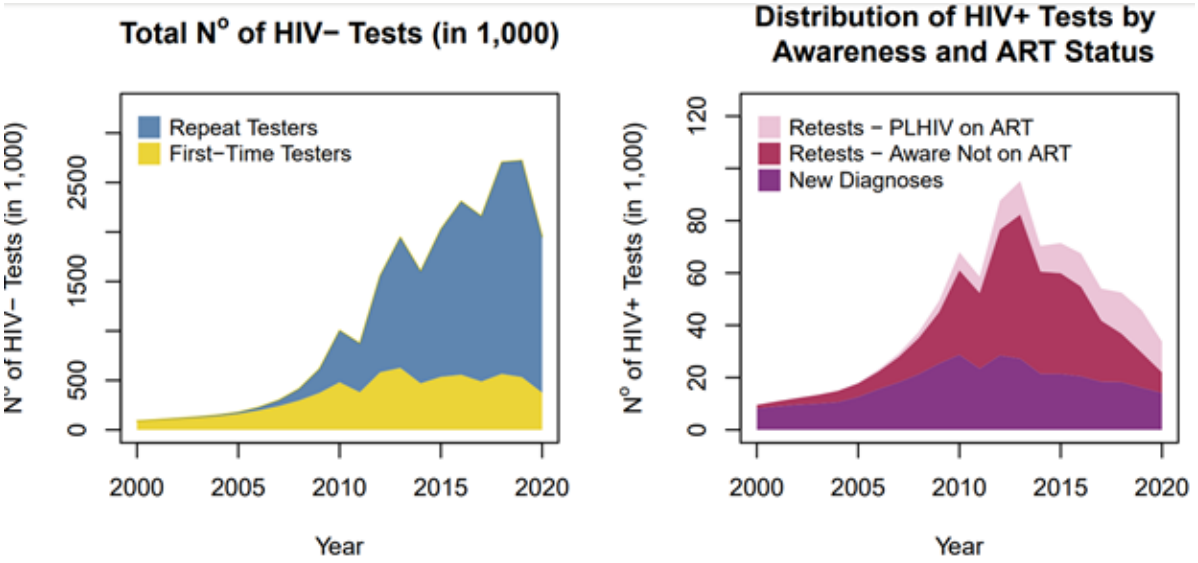
In COP21, emphasis will continue to be placed on improvements in the quality of clinical services, effective and efficient counseling, and coordinated case management at high impact and moderate impact sites to promote continuity of treatment, increase TLD transition, improved VLS, enrollment of PLHIV in community ARV and/or MMD, and increase client engagement across the continuum of care.

The program will engage with the MSHP for a broader national HRH strategy. The USG team will work with district government for effective targeted supervision/mentoring and coaching of care providers on targeted testing and other policies, HRH performance review, providers motivational strategies, service quality management, data quality management and use of data for decision making on a monthly (high impact) or quarterly basis (moderate impact sites).

Case Finding Strategies:

Key challenges mentioned in Côte d'Ivoire's COP21 planning level letter were the lack of progress in a) finding new HIV-infected persons through targeted index testing as demonstrated in findings presented by UNAIDS using 2020 Spectrum estimates (see Figure 4.1.1 below), and b) linkage from testing into care, especially among men, adolescents, and children.

Figure 4.1.1.1 National Data Demonstrating Many Repeat Testers



While the latest spectrum estimates show a relative overall high ART coverage (74%) among PLHIV, there is disproportionately low achievement for children (49%) and men (61%) as compared to women (83%). However, the total number of women yet to be diagnosed still outpaces men and children combined. The district level dyad analysis shows significant differences with many districts still below 50% ART coverage and by subpopulation. COP21 HIV testing strategies are developed to address the critical barriers and provide a client-centered approach to close the gaps by subpopulation and district.

COP21 Facility-based Testing strategies

Facility-based targeted testing will be scaled up using the screening tool at all supported sites. The primary means of support to the sites for scale up would be through direct service delivery (including HRH placement at the sites). In addition, health provider capacity will be reinforced through trainings, refresher courses, and coaching. Close IP supervision will ensure compliance with SOPs and high-quality care. PEPFAR CDI will support universal testing for hospitalized children and children with malnutrition and TB. Universal testing for adults will continue for TB patients and women in ANC.

The family care center at the facility level will be leveraged to actively screen and follow up children of women living with HIV (WLHIV). Women and children attending health facility units (vaccination, Family Planning, STI etc.) will be provided HIV services on a voluntary basis. EID coverage will be increased, especially for <2-month-olds, using dried blood spot (DBS) samples. Continuous quality improvement (CQI) for HIV testing will be scaled up through capacity building of providers and the use of proficiency testing panels. PEPFAR CDI will continue to engage MOH staff on targeted testing, optimized patient flow, and data integrity.

Scale up Facility and Community Index Testing

a. Adult Index Testing Priorities (for Pediatric Case Finding, see Section 4.1.2)

PEPFAR CDI will scale up safe and ethical testing at all sites, including monitoring of IPV. The adult index testing elicitation ratio will be increased through enhanced counseling, support for disclosure, ensuring that contacts are tested, as well as providing messages of hope and stigma reduction at both community and facility-level. Community-facility collaboration with be strengthened by early linkage of newly tested positive with community lay workers and case

conferencing. To address challenges in contact tracing by clinical and community partners, SOPs have been revised in COP20 to reflect a client-centered approach and fast-track the engagement of community lay workers (CLW) in the follow up of index contacts. During post-test counseling, facility lay workers (FLW) will introduce newly tested positive clients to the multidisciplinary team, including CLW. This will contribute to improved index contact tracing by both facility and community lay workers, and other clinicians in accordance with safe and ethical standards. Contact tracing will continue for all newly-identified positives. Index testing services will prioritize individuals newly testing positive, viremic patients, and ART patients who have never received index testing services. The program will ensure adequate HRH to support index testing services through the ongoing analysis and monitoring of HRH requirements. The district level dyad performance analysis will continue to improve partner management. Implementing Partners will leverage and build upon best practices from ICAP and IRC to successfully scale up targeted testing. PEPFAR-CI interagency team will strengthen oversight and implementing partner management through:

- Weekly and monthly review of results
- Weekly IP calls
- Weekly follow up with poor-performing sites by USG staff and IPs through teleconference, in-person visits, and development and implementation of timebound and specific remediation plans.
- Prioritize visits at non-performing sites
- Pair high performing sites and low-performing sites for coaching and sharing of best practices

Strategies to improve Index contact elicitation

Index testing elicitation has been suboptimal and PEPFAR CDI will take the following actions to increase the elicitation ratio. Providers will be encouraged to obtain informed consent prior to the elicitation interview and before contacting sexual partners and biological children. All newly identified HIV positive clients will be referred to a trained lay counselor to receive index testing services. Providers will be encouraged to allow sufficient time for elicitation of partners and biological children as well as building trust with the clients. Counseling will emphasize the 4 different options for partner elicitation, based on patient preference, to address fears of unwanted disclosure. Providers will be mentored on proactively identifying IPV, reporting concerns of violence. The newly diagnosed clients who may not feel comfortable providing partner information during partner elicitation will be provided HIV self-test kits for sexual partners and biological children > 2 years.

Scale up HIV Self-Testing

The distribution of HIV self-test kits will be targeted for hard-to-reach priority groups. The beneficiaries of HIVST kits will be the contacts of index clients that are hard-to-reach or unwilling to meet a provider; AGYW, in some cases, biological children (2 + years old), and men. PEPFAR CDI will support targeted training and distribution of STKs within strategic community networks (men & women). Facility and community providers will continue to track the distribution, use, and reactive results through telephone calls and home visits. The results will be captured in registers to monitor the cascade of HIVST distribution. The program will ensure the availability of HIVST kits, brochures, materials, and provider support to assist clients.

Scale up best practices

Targeted Community Testing (Men, Women outside of ANC, Peds) in selected districts with the largest gap in case finding.

Community -based targeted testing encompasses a variety of outreach strategies tailored to reach specific populations who are less likely to come to health care centers. Based off the dyad analysis of the gap by population and districts, specific interventions will include targeted multi-disease wellness campaign using the screening of high blood pressure (HBP), diabetes, and HIV focusing on men and women that will be conducted in sites with the largest gap in ART coverage and case finding. Priority areas will be where known sexual partners live.

Other modalities targeting high-priority populations include community outreach testing for those pregnant women missing ANC visits; group sessions for AGYW (DREAMS) in the four DREAMS districts; and workplace/informal sector testing (men, women and AGYW). The program will ensure there is adequate HRH for quality services and appropriate data management.

Community-based, mobile testing and moonlight testing will be based on the use of a screening tool and limited to high-burden geographic areas including bus stops (truck drivers, street vendors), bars, neighborhood playgrounds for men, hair salons (men and women), and informal community clinics (clinique boutique). The community-based HIV services will also target young people and individuals who may be less likely to be seen or tested in facilities. This strategy will aim to capture asymptomatic persons who are potential sources of ongoing transmission. All positive cases will be immediately linked to treatment and TB testing, and as mentioned above, expansion of the CommCare tool will facilitate patient-level tracking across community and facility spaces, for accurate linkage reporting.

HTS cross-cutting issues

PEPFAR CDI will continue to address cross-cutting issues that impact case finding and linkage services. They have been mentioned in each section above and summarized as follows: i) implementation of SOPs with fidelity, ii) scaling up safe and ethical index testing; iii) assessment and capacity building to meet the standards, including TB services; iv) assessing and providing HRH support as needed for different strategies; v) ensuring data quality and integrity of HTS services; vi) developing a dashboard and expansion of CommCare to monitor the collaboration between clinical and community partners on HTS and Linkage; vii) adapting strategies to respond to case finding gap by population and geography. Key barriers at the community-level, including stigma and out of date HIV-knowledge, will be reduced through Messages of Hope and prevention activities to strengthen demand for testing among at-risk individuals. The Circle of Hope community post model will be leveraged to increase uptake of testing among men. Finally, in alignment with the evolving epidemic and progress towards 95-95-95, strategies will be calibrated to district-level gaps for sub-populations. PEPFAR IPs will employ mostly passive case-finding strategies in low ART-gap districts, whereas in districts where gaps are larger, more intensive and costly active case finding will be implemented.

Adaptations to COVID-19

In the first few months of the COVID-19 pandemic, PEPFAR IPs developed contingency plans to adapt to a changing and more restricted environment. Most direct-patient contact was replaced by SMS, phone calls, and rare home visits to follow-up hard-to-reach clients. All providers and stakeholders complied with infection prevention measures. During this period, the IPs expanded the distribution of HIVST for target populations including men, adolescents, KP, and military. To mitigate community resistance to HIV testing due to COVID-related rumors, KP partners expanded the preparatory phase to combat rumors through community dialogue prior to testing interventions, yielding positive outcomes. Presently, program implementation is gradually returning to pre-COVID-19 approaches but the preventive measures of physical distancing, wearing masks, and hand washing are still enforced. Given the ongoing COVID-19 risks, in COP21, community-based testing will include phone-based counseling and contact elicitation. There will also be more rigorous oversight of the supply chain for HTS commodities (RTK, EID, and HIVST kits).

Table 4.1.1.1: Summary of Case Finding Strategies for Adults

Facility-based HTS	**Community-based HTS**
Adults	
Targeted testing with screening tool	Index testing
Index testing	Targeted mobile testing (including Wellness campaign)
Universal testing for ANC women (PMTCT)	Community outreach testing as part of ANC defaulter (pregnant women)
Universal testing for TB patients	HTS for AGYW (DREAMS) in the four DREAMS districts
HIVST	Workplace/informal sector (men, women and AGYW) 1. HIVST 2. Outreach testing using a screening tool
	Mobile Testing/Moonlight testing/hotspot testing using RST (men & women: Bars (KP), Bus stop (Trucker, Street vendors/small road vendors), Restaurants (KP), Sport (soccer for men), Hair salon (men and women), Clinique boutique
	Referral and linkage of non-KP individuals identified through KP interventions

Table 4.1.1.2: Summary of Case Finding Strategies for Children

Facility-based HTS	**Community -based HTS**
Pediatrics	
Index testing	Index testing
Targeted testing using the screening tool	Testing for OVC beneficiaries with unknown status
Universal testing for patients presenting with TB symptoms	
Universal testing for malnourished children	
Universal testing for malnourished children	
EID	
Caregiver assisted HIVST (2+ years old)	

The districts with high and medium gaps in ART coverage are seen in both women and men aged 40-44, and fifty plus.

Table 4.1.1.3: Strategies for Districts with High and Medium gaps in ART Coverage.

Facility Strategies	**Community Strategies**
Index testing	Strengthen community-based index testing
Roll out targeted HIV self-testing for hard-to-reach contacts.	Roll out HIV self-testing targeting discordant couples, index clients unwilling to present themselves for testing, especially KP.
Intensify PITC & Pediatric HIV screening tool	Strengthen OVC testing
Deploy HRH to strengthen facility-based index testing	Support targeted mobile testing: (actively offer testing services in high-yield testing points-home, bars, clubs, places of worship, cruising sites, workplaces, or mobile outreach). Target population: men, young men, adolescents, truck drivers.
Actively offer testing services in high-yield testing points (STI and GBV)	Provide KP testing
Expand services on weekend and evening hour	Support targeted wellness campaign
Provide universal testing (ANC, TB clinics, children with malnutrition and hospitalized)	Workplace/informal sector (men, women and AGYW) 1. HIVST 2. Outreach testing using a screening tool

Table 4.1.1.4: Strategies in Districts with low gaps in ART Coverage.

Facility Strategies	**Community Strategies**
Intensify PITC & Pediatric HIV screening tool	Roll out HIV self-testing
Roll out targeted HIV self-testing	Community-based index testing
Deploy HRH to strengthen facility-based index testing	OVC testing
Actively offer testing services in high-yield testing points (STI and GBV)	Support highly targeted testing in community to reach remaining clients through targeted outreach
Expand services on weekend and evening hours	support KP testing
Provide universal testing (ANC, TB clinics, children with malnutrition and hospitalized)	

Table 4.1.1.5: Strategies in Districts with no gaps in ART Coverage.

Facility Strategies	**Community Strategies**

Testing will decrease intensity at the facility-level (focus on quality and outcomes)	Support Index-case testing
Index testing	
Roll-out HIV self-testing and targeted testing	
Provide universal testing (PMTCTANC, TB clinics, children with malnutrition and hospitalized)	

COP21 Linkage Strategies

In FY20, and as mentioned in the COP21 PLL, PEPFAR CDI's linkage to treatment rate dropped from 99% (FY20 Q1) to 84% (FY20 Q4), despite reports from both community and clinical IPs recording linkage rates of >96%. Further DQAs confirmed data integrity issues in four districts, and specifically regarding linkage of positives identified in the community.

PEPFAR CDI will continue to increase the frequency and intensity of partner management to ensure data quality, integrity, and transparency of positive cases reported and linked to treatment. PEPFAR will train and coach providers how to use updated linkage SOPs with fidelity and will monitor performance. The peer navigators and other lay workers will actively escort all patients for treatment initiation and ensure they are duly registered in treatment registers.

All implementing partners will hold refresher trainings in order to implement the linkage SOPs with fidelity and ensure the same of their sub-partners. All site coordinators are required to review their data BEFORE the weekly joint community-facility meetings. The weekly data review at the site with clinical and community partners, and staff will include validation of referral and counter-referrals. The IPs will reinforce sub-partner oversight in cases identified and linkage to ART. The program will monitor and ensure the availability and consistent documentation of tools (testing register, referral and counter-referral register and forms, ARV codes, ART register). The facility and community partners will work to minimize delays in ART initiation. Partners will need to scale and standardize best practices across the program, such as ICAP's SMS appointment reminder notifications to patients, IRC's innovations to improve index testing among OVC beneficiaries, and effective utilization of CommCare to track individual patients across community and facility. Partners will also need to monitor and address deficiencies in practices and data integrity through a well-defined Data Integrity TWG in collaboration with the MOH and other stakeholders. USG will monitor oversee these practices by conducting weekly reviews of the dashboard, monthly data reviews with IPs, joint site visits and CQI at CQI priority sites/communes.

- ***ART Initiation, Linkage and Continuity of Treatment***

FY20Q1 results saw that 25 districts have <100% linkage rates. The key underlying challenges for linkage to care include but are not limited to double testing of patients already on ART, suboptimal application of established procedures to ensure effective active referral and confirmation of ART treatment initiation for positives identified, fraud and data integrity challenges, suboptimal documentation and data quality challenges for positives identified and referral of positives identified in the community to non-PEPFAR supported sites. To address

this issue, the following interventions are being executed in COP20, and will continue into COP21.

Interventions at facilities:

- Active linkage to ART through:
    - Enhanced post-test counseling
    - Patient navigation to ART initiation
    - Weekly monitoring of linkage as QI measure at 173 high impact ART sites
- ART adherence support through:
    - Enrollment in age-appropriate support groups (or 1:1 support, per patient interest)
    - Fast track med dispensation at facility
    - Multi-month scripting for stable patients (6 months)
    - Facility-based community ART distribution (hybrid model)
    - Clear definition of roles, responsibilities, and expectations for clinical staff in ensuring continuity of treatment
    - Systematic counter-referral to the community LHW, at the time of treatment initiation, for all positives diagnosed within health facilities
    - Identification of a Lay Health Worker responsible for the management of the appointments at sites
    - Improvement in documentation of socio-demographic and contact information in patient charts with recurring updates
    - Alignment of Viral Load and ARV pick up appointment
- Better monitoring through roll-out of electronic ART registers and extended hours (after hours, weekend refills, workplace etc.)

Interventions in the community:

- Active linkage to ART through:
    - Enhanced post-test counseling
    - Accompaniment to ART initiation
    - Weekly monitoring of linkage as QI measure
- ART Adherence support through:
    - Age-appropriate treatment literacy materials and approaches
    - Enrollment in age-appropriate support groups (or 1:1 support, per patient interest)
    - Community based ART distribution
    - Engagement of community leaders
    - Clear definition of roles, responsibilities and expectations for community staff in ensuring continuity of treatment
    - Systematic counter-referral to the facility LHW for treatment initiation of all positives diagnosed at the community level
    - Identification of a community-based Lay Worker responsible for the management of the missed appointments referred by health providers

- Improvement in documentation of referral and counter-referral register with recurring updates
- Home visits for handing over ARVs in the community for ART patients who missed their appointments hose the list has shared by health providers

Table 4.1.1.6 Case finding and ART Initiation and Continuity of treatment Strategies to Reach Men by age band

Age	Case Finding	ART Initiation and Continuity of treatment
15-19	**Interventions at facilities:** • Intensified index HTS • Improved counseling messages • STI clinic • OPD risk screening **Interventions in community:** -Index HTS Linkage through youth prevention platforms: prevention, OVC/DREAMS programs. - School health programs - Partnership with FBOs and CSOs to identify at risk youth.	**Interventions at facilities:** • TLD uptake • Patient navigation • MMD **Interventions in community:** - ART Adherence support through: o Home visits for patients in need • Psychosocial support for caregivers • Disclosure and adherence support through the OVC program - Dedicated hours with school/student program
20-24	**Interventions at facilities:** - Provider initiated Self-testing -HIV testing at STI clinics-Intensified index HTS **Interventions in community:** - Embedded testing as part of a wellness/multi-disease integrated package (malaria, TB, alcohol abuse and smoking cessation) at workplaces, unions, male oriented gatherings Grins - Self-testing - Targeted mobile testing - -Interventions to reduce HIV stigma and strengthen HIV literacy	**Interventions at facilities:** - TLD uptake - MMD Improved linkage to ART through - Expansion of ART services in universities and workplace health centers with high yield HIV testing - Extended hours - Scale up Men friendly clinics (with male providers) **Interventions in community:** - Differentiated care and treatment support - ART through Drop-in centers (KP) - Community-based ARV distribution - Interventions to reduce HIV stigma and strengthen HIV literacy
25+	**Interventions at facilities:** - Other PITC reporting modality unpacked to optimize high yield entry points - Systematic index testing through facility-based testing entry points (Internal medicine, TB and STI) and referral to preventive health services and counselors	**Interventions at facilities:** -TLD uptake -MMD - Active linkage to ART through: o Expand ART services in workplace health centers with high testing yield o Focus on districts with high volume of positive cases identified low adult men ART

	- Replication of best practices found at high volume and high yield sites - Self-testing - Involvement of the workplace medical center **Interventions in community:** - Index testing - embedded testing as part of a multi-disease integrated package (malaria, TB, hypertension, diabetes and smoking cessation) at workplaces, unions, male oriented gatherings - Self-testing - -Interventions to reduce HIV stigma and strengthen HIV literacy	coverage and tailor DSD services accordingly by age - ART Adherence support through expand multi-month prescriptions for stable patients - Extended hours - Scale up Men friendly clinics with male provider champions **Interventions in community:** - Differentiated care and treatment support - ART through Drop-in Centers (KP) - Community-based ARV distribution - Interventions to reduce HIV stigma and strengthen HIV literacy

4.1.2. Children and adolescents' strategies

Case Finding

The number of children receiving ART nationwide increased by 48% between 2014 and 2020, with children under 15 accounting for approximately 5% of the treatment cohort. National data show that pediatric ART coverage is proportionately lower at 49%, compared to 74% for all PLHIV in Côte d'Ivoire. As a result, PEPFAR-CI is working closely with the GoCI and other stakeholders to fast track the pediatric HIV response and rapidly scale up pediatric case finding and ART coverage. The program aims to achieve 90% ART coverage among children by the end of FY2022, with a 50% reduction in mortality rates.

FY2022 goals are to (1) ensure that the majority of high-yield HTS and PMTCT sites offer testing for children and adolescents, with risk assessments conducted for 100% of OVC with unknown HIV status to identify those in need of HTS, through strong collaboration between facilities and community settings, and (2) to start and retain on ART all infected children regardless of age. Key priorities for pediatric and adolescent care and treatment in FY2021 include increasing ART and VL testing coverage and suppression rates, TB prevention through TPT, expanding nutritional assessment counseling and support (NACS), and increasing systematic and routine HTS of all children, through a family-centered approach in the index testing context, and same day initiation of ART for those positive, especially:

- Index testing in family context
- HIV testing in in-patient and high risk entry points as well as scale up of HIV risk screening in pediatric OPD and OVC
- Increase PMTCT early infant diagnosis (PMTCT_EID) 2-month coverage and PMTCT final outcome (PMTCT_FO) to ≥ 80% by scaling up access to EID point-of-care machines
- Improve mother-infant pair continuity of treatment throughout pregnancy and breastfeeding by using the cohort registry

- Enhanced tracking of HIV exposed infants (HEIs) not enrolled in care after birth, systematic screening of HEI at routine MCH visits, and optimized ANC counselling messages
- Enroll HEIs in OVC programs, provide peer support for mothers during pregnancy, and track mother-baby pairs via case management to improve EID 2 months and Final Outcome results
- Ensure availability and use of postnatal infant prophylaxis
- Implement Point of Care (POC) for viral load monitoring to identify exposed infants who may need intensified postnatal prophylaxis
- Leverage OVC program to provide treatment education, adherence counseling, and age-appropriate disclosure support to improve continuity of treatment and achieve viral load suppression among children and adolescents with HIV.

ART Initiation and Linkage:

For FY2022, the program will scale pediatric surge efforts to an additional 140 sites with the provision of dedicated staff (healthcare workers and lay counselors), TLD for PLHIV weighing >35 kg (including adolescents and women of childbearing potential), and transition to other DTG-based regimens for children of all other weight categories through the Pediatric ART Optimization Plan, to reach epidemic control among HIV infected children and adolescents. When added to the 95 pediatric surge sites of COP20, the proposed additional 140 sites in COP21 would ensure coverage of at least 80% of C/ALHIV at PEPFAR-supported sites. With the adoption of new pediatric treatment guidelines in FY21, PEPFAR and implementing partners have developed a road map to scale up transition of DTG 10 and DTG5 among children <20 kg. The COP20 plan has prioritized newly enrolled children on ART and those with unsuppressed viral load. This will be expanded in COP21 by targeting all children <20 kg at all supported sites and phase out of LPV/r containing regimen.

Aligning with the task-shifting policy, PEPFAR-CI, through monthly site visits and IP monitoring, will continue to build the capacity of general practitioners, nurses, and midwives to effectively initiate pediatric HIV care and treatment, and ensure that training of staff on the most recent ART guidelines and administration of ARVs. Additionally, the program will support the Ivorian Society of Pediatricians (SIP) that will go hand in hand with the establishment of a mentoring system implemented at prioritized sites.

PEPFAR-CI will also support differentiated service delivery models for children and adolescents meeting the definition of "stable" patients. This includes three-month ARV dispensing and clinical consultation visits for children, or six-month dispensing and clinical consultation visits for adolescents, as well as community ART distribution or fast-track facility pick-up for stable patients/families.

PEPFAR-CI is now monitoring site level achievement monthly and working to collect and analyze testing yield and linkage to ART data from identified pediatric testing entry points on a weekly basis. The generation of a monthly listing of newly tested positive children has led to increased pediatric case finding and treatment coverage; the program will scale up this practice across all IPs to facilitate the monitoring of pediatric enrollment in and adherence to treatment.

PEPFAR-CI will strengthen collaboration and cross-referral between clinical HIV programs, social welfare/community-based support systems, and OVC services to support clinic-based linkage and continuity of treatment efforts.

The program has the objective of ensuring 95% suppression among all children on ART by COP21. To facilitate early identification of treatment failure in infants, PEPFAR-CI will use VL testing as the only routine biological monitoring test in all supported sites. Each of the 235 pediatric sites will have a focal point for follow-up of children with unsuppressed VL who will link to the laboratory focal point. Each laboratory generates a weekly list of unsuppressed VL which will highlight children with unsuppressed VL to provide to facilities, which in turn will conduct active follow-up for supplementary patient and caregiver education, and enhanced adherence counseling support on a monthly basis. As per national guidelines, children receive a VL test every six months; but those with unsuppressed VL will receive a second test after three months. Testing for infants in remote sites with no available VL testing services will use Dried Blood Spot (DBS) samples.

Tables 4.1.3.1 and 4.1.3.2 outline comprehensive care and support models by age groups for children and adolescents.

Table 4.1.2.1 Comprehensive Care and Support Models for Pediatrics

Age	Facility	Community
First 95 (Case Finding Strategies)		
<1 year old	• Systematic EID (both conventional and POC) for HIV-exposed infants to improve 2-month EID coverage.	• Sensitize parents of infants with no EID performed in order to test them through DBS or POC machine for increasing 2-month EID coverage
	• Expand use of EID/POC to increase 2-month EID coverage (POC will be placed in ANC and vaccination service to reach maximum number of babies less than 2 months old)	• Increase enrolment of mother-baby pairs in OVC programs
	• Increase enrollment of mother-baby pairs in OVC programs	
	• Improve referral/linkage to KP program for children of KP	• Educate HIV-positive pregnant couples on attending ANC care and to delivery at a health facility
	• Leverage OVC program to educate HIV-positive pregnant women on the importance of attending ANC care and to delivery at a health facility	• Use lay workers to review mother and child booklets to ensure that HIV-exposed infants receive EID
	• Conduct and scale index testing with fidelity	• Implement community Index testing champion to coordinate community-based index testing service delivery
		• Index testing of children of HIV-positive women regardless of VLS

Age	Facility	Community
		• Conduct and scale index testing with fidelity
		• Conduct weekly review of pediatric case finding (EID, screening tool, index testing) results at all sites with CLHIV
1-10 years	• Monitor sites for consistent use of screening tool to improve targeted testing at OPD (malnutrition, inpatient)	• Increase enrollment of mother-baby pairs in OVC programs
	• Systematic testing of pediatric TB cases and TB suspects	• Educate HIV-positive pregnant couples on ANC care and delivery at a health facility.
	• Train and put in place facility index testing champion	• Lay workers to review mother and child records to ensure all HIV-exposed infants receive EID
	• Index testing of children of all HIV-positive women men if mother's status is unknown or dead	• Identify community Index testing champion to coordinate community-based index testing service delivery
	• Systematic Referral/linkage to OVC and KP programs	• Index testing of children of HIV-positive women regardless of VLS
	• Conduct weekly review of facility pediatric case finding results	• Index testing of children of HIV-infected men if mother's status is unknown or dead
	• Uninterrupted supply chain for testing commodities	• Conduct weekly of pediatric case finding (EID, screening tool, index testing) results
	• Consistent use of screening tool to improve targeting testing at OPD (malnutrition, inpatient)	• Ensure uninterrupted supply chain for testing commodities
2nd 95 (Treatment and Continuity of treatment Strategies)		
0-10 years	• Identify linkage and continuity of treatment champions to ensure that all HIV-infected children are linked to ART	• Implement community-based adherence support groups for both patients and caregivers
	• Organize adherence support for patients and care givers	• Strengthen community based EAC
	• Scale-up task shifting to non-pediatricians to ensure timely ART initiation and follow-up	• Support tracking a search of miss appointment and IIT
	• Monitor critical interventions, including EAC and transition to optimized ART regimens	• Train and coach lay-workers and caregivers of infected children on the correct use of pediatric formulations, including LPV/r pellets
	• Conduct a pediatric surge at high volume sites to improve clinical cascade	• Ensure enrolment of children of KP

Age	Facility	Community
	• Ensure systems are in place to track missed appointments and IIT	• Increase enrolment of mother-baby pairs in OVC programs
	• Implement pediatric case management that includes intensified support (via text messages and home visits) for caregivers of children, and directly to adolescents with unsuppressed VL	
	• Train and coach lay-workers, clinicians, pharmacists, caregivers of infected children on the correct use of pediatric formulations, including LPV/r pellets	
	• Increase enrolment of mother-baby pairs in OVC programs	
	• Ensure uninterrupted supply chain system for ARV drugs	
3rd 95 (Viral Load Coverage/Suppression)		
0-10 years	• Scale-up treatment and VL literacy for patients and caregivers to include U=U messages	• Scale-up treatment and VL literacy for patients and caregivers to include U=U messages
	• Transition all children on optimum ARV regimen and formulations	• Scale pediatric community-based friendly services and peer support groups around high-volume sites
	• Scale pediatric friendly services and peer support groups in high volume sites	• Assess reasons for unsuppressed VL and provide EAC support (via text messages and home visits) for children with unsuppressed VL
	• Assess reasons for unsuppressed VL and provide EAC support (via text messages and home visits) for children with unsuppressed VL	• Strengthen linkage with OVC and nutrition programs to ensure that children receiving ART have additional continuity of treatment and viral load counselling services in the community
	• Provide age-appropriate disclosure and psychosocial support, addressing stigma/discrimination among other barriers to adherence	• Weekly review of VL coverage and suppression data with facility providers as part of the clinical/community collaboration

Age	Facility	Community
	• Implement an electronic early warning system from the laboratory to the clinic with the goal of reaching children with unsuppressed VL within one week of clinics receiving the result	• Scale-up treatment and VL literacy for patients and caregivers to include U=U messages
	• Increase enrollment of mother-baby pairs in OVC programs	• Scale pediatric community-based friendly services and peer support groups around high-volume sites
	• Scale-up pediatric Advanced Disease Package (TB, CrAg, CTX) in prioritized sites	• Assess reasons for unsuppressed VL and provide EAC support (via text messages and home visits) for children with unsuppressed VL
	• Weekly review of VL coverage and suppression data	•

The Pediatric Case Management Tool will be used to monitor approaches centered on children and adolescents at monthly basis.

Table 4.1.2.2 Comprehensive Care and Support Models for Adolescents

Age	Facility	Community
First 95 (Case Finding Strategies)		
10-19 years	• Targeted testing using the screening tool at all facility-based entry points, including sexual reproductive health services	• Index testing
	• Scale up index testing with fidelity	• Implement youth social networking testing
	• Expand HIV self-testing among high-risk youth	• Expand self-testing among high-risk youth (HIVST)
	• Coach providers, parent/guardians on HIV status disclosure, including to family/care givers	• Testing for high-risk adolescents (DREAMS)
	• Expand HIV testing in school health program targeting high risk youth (STI, pregnant)	• Link youth with community-based prevention programs (OVC/DREAMS/AGYW)
	• Implement flexible hours and youth friendly clinics	• Coach providers, parent/guardians on HIV status disclosure
	• Collaborate with school health care centers to identify at risk children in need of HTS	
2nd 95 (Treatment and Continuity of treatment Activities)		
	• Establish adolescent support groups in high volume sites and use adolescent peer counselors	• Strengthen community-based adherence and continuity of treatment counseling

Age	Facility	Community
10-19 years	• Identify adolescent champions and establish multi-disciplinary facility switching team (clinician, pharmacist, counsellors, phycologists if available) to ensure adolescents receive treatment and are retained	• Link youth with community-based prevention program to improve continuity of treatment (OVC/DREAMS/AGYW)
	• Support caregivers to teach adolescents how to adhere to their medication	• Coach providers, parent/guardians on HIV status disclosure
	• Enhanced partner management to ensure supportive supervision (SS), mentorship or coaching on peds and adolescent ART provision and VL management	
	• Conduct weekly review of adolescent clinical cascade indicators	
	• Coach providers, parent/guardians on HIV status disclosure	
	• Track and monitor adolescent in TLD transition and MMD interventions	
3rd 95 (Viral Load Coverage/Suppression)		
10-19 years	• Scale-up treatment and VL literacy for children and caregivers	• Scale-up treatment and VL literacy for patients and caregivers to include U=U messages
	• Incorporate U=U messaging into all clinical review visits	• Establish community-based adolescent friendly services and peer support groups around high-volume sites
	• Transition all adolescents to optimum ARV regimen and formulations	• Assess reasons for unsuppressed VL and provide EAC support (via text messages and home visits) for adolescents with unsuppressed VL
	• Scale adolescent friendly services and peer support groups in high volume sites	• Strengthen linkage with OVC and nutrition programs to ensure that adolescents receiving ART have additional continuity of treatment and viral load counselling services in the community
	• Assess reasons for unsuppressed VL and provide EAC support	• Weekly review of VL coverage and suppression data with facility providers as part of the clinical/community collaboration
	• Provide age-appropriate disclosure and psychosocial support, addressing stigma/discrimination among other barriers to adherence	
	• Implement an electronic early warning system from the laboratory	

Age	Facility	Community
	to the clinic with the goal of reaching adolescents with unsuppressed VL	
	• Scale-up adolescent advanced disease package (TB, CrAg, CTX) in prioritized sites	
	• Weekly review of VL coverage and suppression data	

4.1.3. Tuberculosis/HIV and Advanced HIV Disease strategies

TB is the leading cause of death among PLHIV in Côte d'Ivoire. In 2020, the mortality rate for TB/HIV co-infected patients was 20%. In Cote d'Ivoire, PEPFAR and implementing partners support PNLS/PNLT with integrated TB/HIV care and treatment services at the national, regional and district levels in 79 Districts. During FY20 HIV services were integrated in 100% TB clinics, 100% of new and relapsed TB cases knew their HIV status and 97% of the 2,323 HIV positive TB cases received ART. TB screening diagnostic and treatment among PLHIV: (include graph see example below). Integration of TB screening, diagnosis and TB prevention in ART clinics remains inadequate. During FY20, 94% of PLHIV on ART were screened for TB but only 0.3% were positive for TB symptoms – a lower achievement than the expected target ranging from 5% to 10%.

In COP 20, PEPFAR-CI is working with PNLS/PNLT and GF to develop an integrated policy that aligns with PEPFAR priorities for TB/HIV as outlined in COP20 guidance. Specific strategies include: 1) HIV testing for all presumptive and confirmed TB patients in TB clinics and hospitals, with the goal of achieving 100% testing for these groups; additionally, the program continues to implement the "Engage TB Strategy" using a family approach to reach the missing TB/HIV cases; 2) tracing and screening contacts of patients with TB; 3) rapid ART initiation for PLHIV who screen negative for TB and TB/HIV co-infected patients according to national guidance, 4) systematic symptom TB screening for all PLHIV at all routine encounters 5) prioritizing GeneXpert testing and immediate TB treatment for all ART clients screening positive for TB symptoms in the absence of contraindications 6) expanding availability and use of a point of care TB test, urine lipoarabinomannan (TB LAM) and CrAg tests for PLHIV presenting with advanced disease in 30 high impact sites, for selected patients with Advanced HIV disease according to the COP20 guidance; 7) initiate TPT for all eligible PLHIV who screen negative for active TB ; 8) ART provision for TB/HIV co-infected patients in all TB clinics; according to the COP 20 guidance, in 30 high volume ART sites.

Due to high-level advocacy with PNLS/PNLT by PEPFAR, WHO and Global Fund, all the major policy barriers to TB/HIV services identified for action in COP20 namely, (1) removal of Chest X-ray as a requirement for ruling out active TB before TPT initiation; (2) updating the national TB diagnostic algorithm to make GeneXpert the initial diagnostic test for PLHIV with TB symptoms according to WHO guidelines; (3) incorporating TB LAM into the national diagnostic algorithm for TB, for seriously ill patients and those with advanced HIV disease, in addition to developing national tools and training materials; (4) inclusion of shorter-course TPT regimen

into the TB National guidelines; have been successfully lifted. A series of national guidelines and policy updates as well as official notices have been issued in this regard, effectively paving the way for significant scale of priority TB/HIV interventions beginning in COP20 and expanding in COP21.

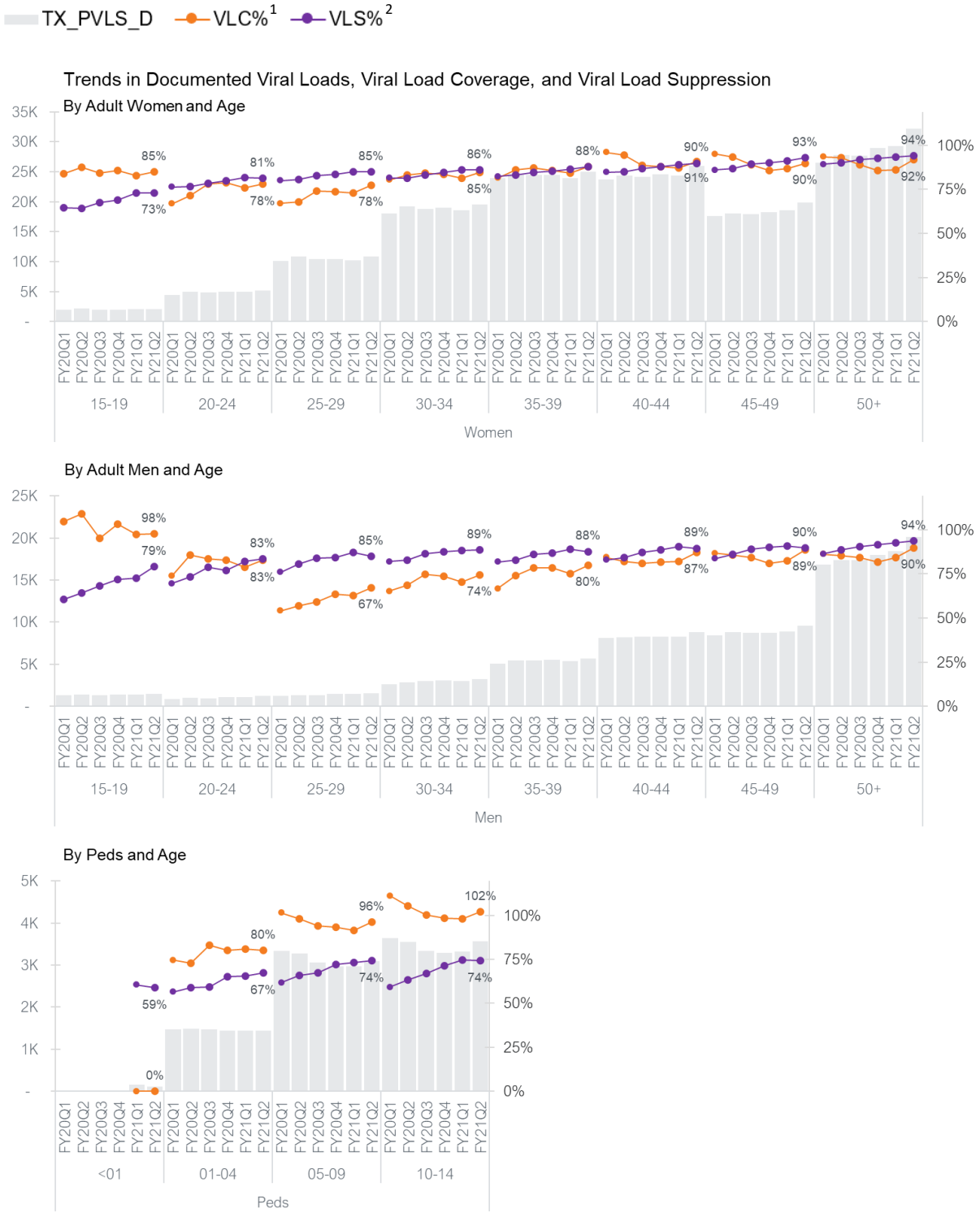
The key priorities for TB/HIV and Advanced HIV Disease in COP21 include:

- Improved quality of TB symptom screening to ensure patients with TB are not missed
    - Training providers on updated WHO screening questions and data collection tools
    - Specimen transport from HIV treatment sites to 27 locations with GeneXpert platforms for diagnosis of TB
    - Active referral of all PLHIV with TB symptoms for diagnostic testing to TB treatment centers
- Improved TB case identification in children, especially in children newly initiated on ART and children with malnutrition
- Nationwide scale up of TPT for all eligible PLHIV including alignment of TPT with Differentiated Service Delivery Models
- Improved HIV screening among TB patients
- Capacity building for providers
- Allocation of already procured key commodities (TPT drugs, GeneXpert cartridges, specimen collection supplies)
- Rollout of Advance Disease package to a total of 60 high volume sites
    - Training of site level providers
    - Launch site-level implementation
    - TA and supervision of implementation sites
    - Data collection and reporting
    - Monitoring and evaluation

4.2 Retaining clients on treatment and ensuring viral suppression

Continuity of treatment of patients receiving antiretroviral treatment (ART) has been a major challenge for PEPFAR-CI over the past two years, including high Interruption in Treatment (IIT) among both men and women. At the end of FY21Q1, only 60% of adolescents age 20-24 (unchanged from FY20 Q4) and 80% of young men age 25-29 years (up from 40% in FY20 Q4) that interrupted treatment, were returned to care. The VLS rate was 88% overall and 73% among children at the end of FY21Q1. Table 4.2.1 illustrates the trends in viral load coverage and suppression by sex and age bands.

Figure 4.2.1 Trends in Documented VL, VLC and VLS by sex and age-bands, FY2020 Q1–FY2021 Q2



1. VLC = TX_PVLS_D / TX_CURR two periods prior
2. VLS = TX_PVLS_N / TX_PVLS_D

PEPFAR-CI, in collaboration with MSHP and implementing partners, has developed a set of Standard Operating Procedures (SOPs), guidelines, tools and materials on ART adherence

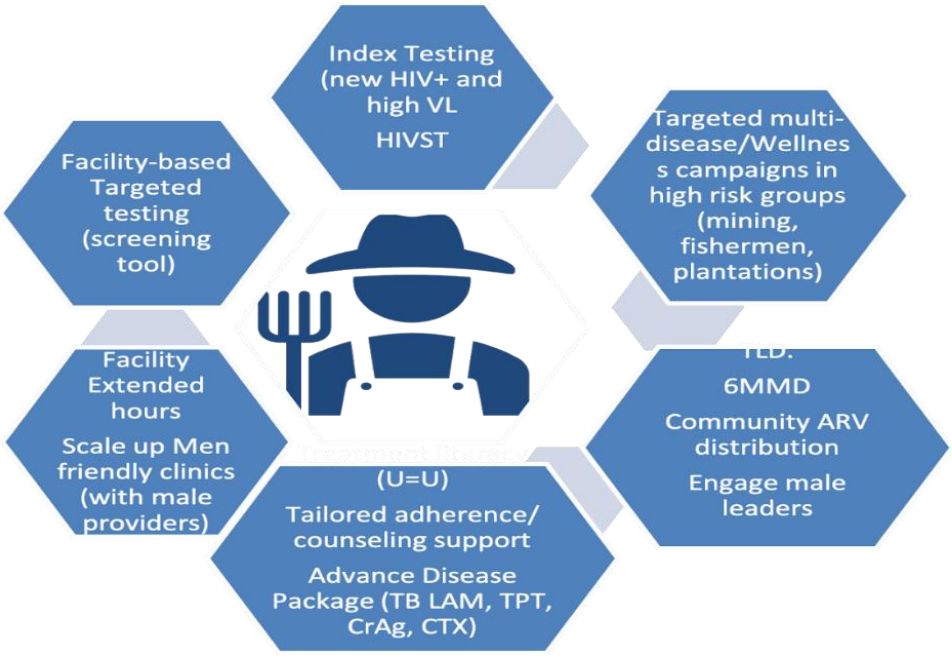
counseling, tracking, and managing of routine patient appointments, and return to care for IIT patients. Implementing partners and PEPFAR staff trained and coached providers, community lay workers and other relevant stakeholders to ensure implementation with fidelity of those tools and materials. As part of these efforts, PEPFAR-CI developed an algorithm to improve and monitor the collaboration between clinical and community partners which is critical in addressing the gaps across the clinical cascade. COP21 planning is based upon optimal HRH to patient ratios and intensified partner management such that sites have adequate and qualified HRH to deliver quality services throughout the cascade, as described in Tables 4.1.3.1 and 4.1.3.2 above or children and adolescents.

Tables 4.2.1 and figure 4.2.2 illustrate COP21 continuity of treatment and viral load suppression packages for specific populations.

Continuity of treatment among men:

Given the disproportionately low VLS rates and clinical outcomes among men, continuity of treatment strategies needs to be patient-centered and implemented immediately. As illustrated in the graphic below, extending hours, differentiating care for stable patients, integrating HIV services into broader wellness approaches, and designating men's champions will render services more accessible and attractive. Counseling messages must be updated and improved, to emphasize accurate risk perception and HTS, early ART initiation, and U=U.

Figure 4.2.2: The Guiding principles of the strategy



For men referred to community services, peer navigators will focus on self-efficacy, treatment literacy around TLD and awareness-raising around DSD options to ensure initiation of treatment even in the absence of symptoms. In all cases, coping potential and self-efficacy will be addressed per Menstar recommendations. Additional detail on services targeting men is illustrated in Table 4.1.1.6.

Continuous Quality Improvement (CQI)

Using data to improve service delivery requires appropriate analysis as well as an effective implementation plan for targeted responses to curb the HIV epidemic in CDI. In an effort to bolster epidemic control, Continuous Quality Improvement (CQI) activities will be integrated with site-level QI coaching to redesign workflows to support accuracy and completeness of data used for decision-making. Site-level technical assistance will be provided to clinical and community IPs to address clinical and community site-level data integrity across PEPFAR indicators, especially case finding, continuity of care, and VLS. Coaching will leverage previous and current DQA work and scale-up of weekly data quality reporting tools. Intensive site level coaching activities will include training of CSOs, TOTs, and SOP development, conducted in partnership with IPs.

PEPFAR will initiate Quality Improvement Learning Networks that involve clinical and community sites at district level. District networks will be based on a hub-and-spoke model, involving drop-in centers, testing sites, community sites, OVC sites, and hotspot areas, all of which connect with the ART site as part of a system in which key target areas are addressed to achieve improvements across the cascade. These QILNs will target gaps that involve relationships between these sites, such as linkage to care, return to care of those IIT, and case finding. Joint QI activities involving clinical CSOs, community organizations and PLHIV to map systems, referral networks, identify root causes and barriers to linkage and treatment, and design interventions that target these areas, improving bi-directional referrals and coordination between facility and community services.

Lessons learned will be shared and synthesized into a package of effective interventions for scale-up through Spotlights and WhatsApp, focusing on strengthening client-centered coordination of services. Such coordination between community and health facilities will promote durable continuity of care. District level performance measured through clinical and community monitoring data dashboards. Customized QM coaching will be provided throughout to all sites targeting identified gaps to improve priority cascade metrics and address case finding, continuity of care, and VLS.

Community engagement is key to understanding priorities for improving care and reducing stigma among PLHIV. PEPFAR will engage CSOs to develop and implement a broad range of community monitoring strategies in Côte D'Ivoire, including training CSOs and community treatment observatory (CTO) among other strategies for gathering community feedback. Concrete interventions alongside QI coaches and sites will facilitate integration, routine use of community monitoring data and promote concrete interventions for integrating and using CM data in QI activities. Evidenced-based strategies for capturing client experience, comment box, hotline, journey mapping, client surveys, and community advisory board used to promote active PLHIV involvement in QI activities "consumer involvement in QI."

At sites level, coaches will work seamlessly with the community to gather information specifically from people who are not engaging in care to identify the causes that can inform development of friendly, stigma-free services to improve linkage and treatment continuity.

Finally, building QI knowledge among community members and civil society organizations enables direct participation in site-level QI activities to ensure routine input of their perspective into priority-setting and identifying interventions. Site-level CQI committees will be established and will meet on a monthly basis to review all the indicators across the clinical cascade, and especially those related to continuity of treatment and viral load suppression. The committee will include representatives of different services, implementing partners, and CSOs. The committee will use various quantitative and qualitative data from different sources (WETMOT, SIMS, GSM, MER, Community-led monitoring etc.) to assess progress in meeting the different benchmarks and to address any challenges across the clinical cascade

4.3 Prevention, specifically detailing programs for priority programming:

HIV prevention AGYW and OVC

The OVC program is implementing in 38 of 79 PEPFAR-supported districts. Three implementing partners (Save the Children, IRC, and SEV-CI) will deliver OVC services in COP21. The OVC program is evolving in a dynamic pandemic to better respond to the specific needs of OVC, in order to improve HIV outcomes among C/ALHIV and HEI, mitigate the risk of HIV acquisition and create resilience among beneficiaries. To that end, the program implements an intergenerational approach focusing on the most at risk such as: C/ALHIV, HEI, CFSW, Adolescent girls, children of PLHIV, Breastfeeding or pregnant Adolescents/women, etc. The OVC community platform will be used to support comprehensive services within the PEPFAR programming by linking HIV-positive beneficiaries to Pediatric, ART and PMTCT services, while supporting continuity of treatment and adherence via case management and socio-economic support. In COP21 an emphasis will continue to be placed on enrolment of C/ALHIV, mother-baby pairs in OVC programs including KP children, on primary prevention of sexual violence and HIV infection for boys and girls (9-14 years old) enrolled in the OVC program, and for girls aged 10-17 enrolled in the DREAMS program.

In Q4 of FY2022, two local partners will be introduced to implement Save The Children's OVC portfolio. The early start-up of these local partners is scheduled to avoid interruption in service delivery in COP22.

A ratio of four children to one caregiver is continued to be reflected in the target to ensure that children under 18 are the focus of the program. The primary caregiver in the OVC household will be served by the program, in addition to all vulnerable children under 18 living in that household. The OVC program will continue to deliver parenting for Lifelong Health programs, including the primary prevention of sexual violence and HIV for boys' and girls' modules in intensification sites. Implementing Partners will continue to implement and routinely monitor the OVC case management plan, as well as assess the achievement of graduation benchmarks for OVC households in order to graduate those reaching the self-sufficient stage despite the context and impact of COVID-19.

HIV risk assessments will be done for all children with unknown HIV status to ensure that those in need of HIV testing are referred and are linked to ART if positive. Those found to be HIV negative or ineligible for testing will receive the primary prevention of sexual violence and HIV intervention. In COP21, the OVC program aims to enroll at least 90% of children and adolescents living with HIV (C/ALHIV) on ART (in OVC districts). The OVC program will also be used as a means to provide age-appropriate disclosure support to children/adolescents living with HIV and their caregivers. In addition, OVC program will help to improve index testing for all biological children and siblings (<19 years with unknown HIV status) of HIV+ mothers.

In close collaboration with clinical facilities and through data-sharing agreements, OVC IPs will monitor viral load data of C/ALHIV on ART to ensure adherence support and viral suppression. Existing MOUs between clinical and OVC IPs, health facility staff, and NGOs will be updated

and strengthened where necessary to improve bi-directional referrals, joint case management, and ensure complementary clinical and community-based service delivery for improved pediatric HIV outcomes. To that end, in COP21, PEPFAR supported treatment clinicians will collaborate with OVC IPs to reinforce capacities of OVC community case workers in adherence, continuity of treatment, and age-appropriate disclosure of HIV status. Similarly, PEPFAR-supported OVC staff will reinforce the knowledge of clinicians in charge of C/ALHIV on the comprehensive community-based social service package offered to OVC.

The linkage with PMTCT services will be strengthened to ensure that HIV positive pregnant women are linked with OVC programs to support ART adherence and continuity of treatment post-delivery and ensure that HIV-exposed infants are enrolled to improve EID 2 months and Final Outcome results. Adolescents and young HIV-positive mothers will be prioritized in enrollment, because they are at higher risk for missed appointments and post-partum IIT.

The PEPFAR-CI OVC program will continue to leverage the DREAMS program when possible. Across the four DREAMS districts, in alignment with SGAC guidance, IPs will make referrals and counter referrals of AGYW aged 9-17 from the OVC program to complement DREAMS services based on their specific needs. To improve coordination of OVC services nationwide, the PEPFAR-CI OVC program will support PNOEV for revision and printing of tools including continued support to the OVC data base.

The calculation of the DREAMS coverage based off the unique criteria of vulnerability by age band shows that the saturation will not be reached during COP20 and that the time needed for saturation per age group and district varies. In COP21, PEPFAR will target strategically in order to reach the saturation goal of 75% coverage in each age group in the 4 districts. Phased saturation should be reached by the end of COP21. Additionally, DREAMS IPs will provide program data to show the number of secondary services provided to AGYW and number of parents and community members reached with contextual interventions, e.g., SASA. Besides the OVC program, DREAMS interventions will leverage existing platforms such as HTS, sexual and reproductive health, ANC, STI, and other prevention programs.

In COP21, DREAMS implementation will continue in the same four districts, Cocody-Bingerville, Abobo-Est, Man, and Daloa. The approach for preventing sexual violence and HIV risk among girls 9-14 years of age will include: reinforcement of community awareness, case identification and reporting by community and school GBV committees and DREAMS mentors; improving violence risk screening through active and early detection of girls facing GBV in their family or community; improving access to post-GBV care by widely spreading information on available post-exposure care services among OVC and DREAMS beneficiaries; and ensuring systematic referral from community to health facility and assistance to victims for non-medical support such as police, judicial, psychosocial support with family involvement. Mentor-led clubs and community mobilization for norms change will continue in DREAMS districts. Given the high rate (17%) of sexual violence among AGYW, in COP21, PEPFAR-CI will ensure that quality and comprehensive post-violence clinical care services are available and accessible to DREAMS beneficiaries. This will be done by creating friendly services for AGYW survivors of emotional, physical, and sexual violence in the four DREAMS districts, including a facility-based package

(comprised of condoms, mixed contraception, HIV counseling, testing and active referral for ART, social protection/ GBV), capacity building of providers and production of prevention and educational materials. DREAMS IPs will continue to refer to non-PEPFAR facilities that provide the full minimum package clinical post-violence care of services and prevention services as well, especially those that are close to AGYW and have partnerships with GBV Awakening Committees.

Through the mentoring system for AGYW and family and community interventions, DREAMS activities will increase awareness and skills to prevent and respond to GBV for girls. These interventions e.g., SASA will reinforce the creation of a safe environment for girls in their families and communities. Caregivers will participate in training on positive parenting specific for adolescents which will promote norms changes, especially around violence prevention, through the evidence-based curriculum Parenting for Lifelong Health or "Ahoundjoue" in local Ivorian language. In addition, in COP21, PEPFAR-CI will scale-up PrEP for the most vulnerable young women, through implementation of intensive community strategies to increase demand creation and reducing barriers to initiation at the facility level (as mentioned in the Key Populations section below).

Comprehensive economic strengthening activities with a link to entrepreneurship and employment will continue to be scaled in COP21. DREAMS IPs will provide program data to show the number of AGYW who have completed each level of Economic Strengthening activities. PEPFAR implementing partners will increase recruitment of qualified DREAMS AGYW for paid positions in PEPFAR program, following COP21 guidance. AGYW who meet the recruitment profile will be prioritized. In addition, the DREAMS program will ensure age-appropriate content and length of program, ensuring that 10 - 14-year-olds are active in DREAMS longer than 6 months. The CSE curriculum will be revised as needed to expand gender and GBV sessions and adapt content for 20 - 24-year-olds. Three AGYW will continue to be employed as facility-based Ambassadors in Man district, assisting on the clinical side by sensitizing clients about the DREAMS program, ensuring bidirectional linkages to DREAMS/OVC at sites and participating in community outreach. DREAMS Ambassadors will also be hired in the other three SNUs with responsibilities around program implementation. In addition, PEPFAR CI will improve mentoring by standardizing the recruitment, selection process and remuneration of mentors across IPs and properly train mentor on identifying and responding to violence - recognizing and responding to trauma including mental health. Mentor to mentee ratios will remain the same, unless smaller groups are needed for COVID protocols.

PEPFAR-CI team will continue to conduct routine technical visits to community and clinical sites (at least monthly) to assess the quality of services related to OVC and AGYW and offer strategies for areas needing improvement, e.g. sensitize clinical site staff on DREAMS program and needs of AGYW. PEPFAR-CI also plans to build upon best practices and lessons learned from the COP20 implementation. Best practices including sharing promising experiences across IPs; conducting joint sites visits; frequent coaching of mentors and facilitators; active participation of community leaders in service delivery; and involvement of beneficiaries in service provision, etc.

PEPFAR-CI's OVC and DREAMS approaches align with government guidelines for child protection and complement activities from other actors or donors, including the Global Fund and UNICEF. The National Program for OVC, the GoCI coordination body for DREAMS and OVC, will strengthen collaboration with the MSHP through active participation in all coordination meetings and joint engagement in material development to ensure sharing of lessons learned and scaling up best practices nationwide.

Children/PMTCT

Côte d'Ivoire's PMTCT program continues to be strong with 98% coverage and 100% of HIV positive women receiving treatment. The COP21 PMTCT package will be implemented at all high, moderate, and low-impact sites in all 79 PEPFAR-supported districts to scale up access of HIV services to pregnant and breastfeeding women (PBFW) in high burden and underserved settings. The strategies for PBFW will include support for demand creation activities and PITC at all mother and child entry points. The PMTCT package will provide HIV testing with same day ART initiation, friendly PMTCT services for adolescents, VL testing among pregnant women, EID for HIV-exposed infants (HEI), and linkage into pediatric care and treatment when necessary. To ensure high HTS coverage in ANC, all PMTCT sites will offer index testing with fidelity targeting partners and sexual networks of HIV-positive women, biological children and adolescents. Self- test kits will be provided for hard-to-reach sexual contacts including the establishment of tracking procedures for the return of self-test results.

To reach 95% 2-month EID coverage, ensure timely return of results (4 weeks or less) and optimal ART linkage, the COP21 program will continue to expand the following strategies: (1) Active tracking of mother & baby pairs; (2) Monitoring of clinical/community collaboration through weekly meeting between clinical and community actors to verify whether HEI have effectively been tested, and (3) Daily monitoring of the mother and infant pair registers to create a weekly listing of HEI needing EID and follow up of EID appointment by phone calls/home visits. In addition, PEPFAR would encourage systematic referral of all CALHIV as well as HEI and their mothers to the OVC program where available.

In COP21, PEPFAR would continue to implement and scale up the following strategies already in place in COP20 to increase access of pregnant and breastfeeding HIV+ women to viral load testing. PEPFAR-CI will provide HRH support (e.g., VL champions) to follow this cohort at site level, as described above for children. Chart review, follow up, and improved documentation will ensure that prenatal and post-partum visits are leveraged for VL sample collection. Dedicated VL champions will also follow up on VL results, ensure results are available to providers and explained to patients, and support treatment literacy. Counseling and support messages will be reinforced to include U=U strategy. Best practices for continuity of treatment and VLC/VLS will be shared among providers and across sites and IPs through the ECHO platform. Finally, expanding access to TLD will be critical to improving VLS rates. In addition to the aforementioned strategies to boost viral load coverage and viral load suppression in PBFW, PEPFAR would also deploy POC machines to 33 additional high volume and

geographically hard-to-reach sites as well as use DBS for VL sample collection for hard-to-reach PBFW and children.

At present, PrEP and MMD for PBFW are not included in national PMTCT guidelines. PEPFAR-CI will continue to advocate through coordination meetings with MSHP and multilateral stakeholders and regular interactions with civil society organizations, for inclusion of PrEP and MMD for PBFW into the national PMTCT guidelines.

Key Populations

In COP21, the KP program will focus on the Transgender (TG) population, MSM and FSW offering a comprehensive package of services in both community and clinical domains. 23 high-volume KP facilities will be supported by PEPFAR with the MSHP-endorsed package of KP-differentiated services, complemented by community interventions. The remainder of traditional public sector facilities will also receive mentorship on providing patient-centered, stigma-free services. Based on COP21 guidance, the KP program will employ a combination of behavioral, clinical and structural approaches to reduce new infections, and improve access to care and support for KP PLHIV.

Strengthened collaboration and coordination between facility and community interventions will ensure tailored KP-friendly services across the entire prevention, care and treatment cascade, including addressing stigma and discrimination. The strategy will also include case-finding to reach men, clients, stable partners and children of FSWs. Thus, the strategy will include development and implementation of psycho-social services for KPs at existing KP-friendly and KP-competent sites and drop-in centers. The PEPFAR-CI KP Program will provide a mix of direct service delivery and targeted technical assistance at designated KP facilities that focus on achieving the 95:95:95 within key populations.

During FY20, the KP prevention program reached 30,379 FSWs and 15,850 MSM and TG with HIV prevention interventions for a total of 46229 KP clients. This represents 143% achievement of the target. For HIV testing, newly KP tested or referred for testing represented 63.52% (29 365) of the results.

A slight underachievement was noticed for the TG population due to the lack of a focused strategy. Recently, Global Fund provided size estimation and needs for the TG community in Abidjan.[9] PEPFAR-CI will collaborate with MSHP and all stakeholders on the national strategy development.

In COP21, PEPFAR will implement targeted testing interventions for KPs by reinforcing social network strategies to reach the most at-risk and most hidden KPs, including intensifying peer education. Self-testing will be scaled up among MSM, FSW, TG and their stable partners. Index testing will continue to be implemented with fidelity and in line with SGAC index testing

[9] MSHP PNLS, 2020. Note Technique révisée sur la triangulation des données en matière de populations clés en Côte d'Ivoire.

guidance to conform to minimum ethical and safety standards for all community members, including implementing IPV risk assessment and service provision.

The program will couple index testing with self-testing to reach the hard-to-find FSW, MSM, as well as their sexual partners, through peer navigators. Self-test achievement will be improved by training more peer navigators on the national guidelines on self-testing and on key messages about the availability and accessibility of KP-friendly services to overcome access-related barriers and strengthen demand for services. Demand for self-testing will be created through standard outreach/SBCC messaging, online outreach, support groups, and home visits to KP living with HIV by peer educators and navigators.

In COP21, KPIF-like activities will continue to allow KP partners to more closely consult communities on improved strategies for self-testing and index testing; address barriers to PrEP adoption across KP sub-populations; provide organizational support to PLHIV and KP networks and KP-led groups; provide care and treatment services at one DIC; and support KP-led and competent organizations to fund initiatives to prevent and respond to incidents of violence, address stigma and discrimination, and provide legal literacy training across KP communities.

Some KP continue to decline HIV testing, for several key reasons: they know their status and do not want to disclose it to the community tester (peer educator), others prefer to be tested in health facilities, or some fear a positive HIV test result. The KP program will improve counselling through training and ongoing mentoring to reduce the HIV testing refusal rate. Training and mentoring will include WHO HIV testing standards to ensure the "5Cs" are observed (consent, confidentiality, counselling, correct test results and connection to HIV prevention, treatment, and care) and Intimate Partner Violence screening and referrals are implemented as standard practice. Additionally, counselling will include routine use by peer educators of risk assessments that identify KP with high-risk factors for HIV exposure and provide education on the benefits of testing and treatment, including U=U messaging. Finally, this underscores the importance of ongoing efforts towards stigma reduction at facilities and throughout the community.

The overall expected testing yield for FSWs is 11. %, 13% for MSM and 16% for TG.

The strategy aims to reinforce KP friendly training & oversight among service providers to ensure KP friendly services across the full cascade, and to oversee the 4 existing Drop-In Centers in Cocody, Attecoube, Bouake and Yopougon East.

In COP21, community KP partners will closely consult communities to improve strategies for self-testing and index testing; promote PrEP adoption across KP sub-populations, emphasize demand creation to increase PrEP uptake among those at highest risk; provide organizational, management and technical support to KP networks, KP-led groups; support KP-led and competent organizations to fund initiatives to prevent and respond to incidents of violence, address stigma and discrimination, and provide legal literacy training across KP communities.

The KP program includes an overall package of services for KP across the cascade with overarching approaches tailored to the needs of MSM, FSW and Transgender beneficiaries. The KP program is comprehensive and managed in a way to adapt and ensure that previously

underserved populations receive client-centered care in line with WHO Normative Guidance on the provision of services for key populations. For FSW and MSM who are more active in hotspots, a package that is similar may be required, whereas undisclosed MSM or FSW who are not open about selling sex will require a similar package, differentiating by how they access services. The options for differentiated care include prevention and case finding modalities such as social network testing and referrals, index testing, HIV self-testing, and PrEP screening and enrollment; linkage referrals and treatment initiation; and case management, including viral load tracking and follow-up. The KP program will continue to work closely with KP community organizations to adapt these approaches to meet the unique needs of MSM and FSW beneficiaries.

Additional strategies will include DICs for MSM , FSW, TG with providers and staff specifically trained to meet individual and community health needs; recruiting peer educators and navigators with ties to MSM, FSW, TG community networks; creating online outreach strategies with specific approaches to reach hidden high-risk individuals and social networks, especially for MSM; and incorporating human rights and GBV response activities appropriate to the specific needs of MSM, FSW, TG communities. In COP21, to better address GBV among KP, the 4 DICs will provide a continuum of services including legal, juridic, psychosocial, and transit accommodation package for KP victims. Finally, the KP program will continue routine analysis of KP data disaggregated by KP type and engage in continuous quality improvement to refine programming to meet specific targets for MSM, FSW and Transgender beneficiaries. In Table 4.3.1, a KP Layering Table is provided to further illustrate how the KP program will target services to MSM, TG, and FSW beneficiaries.

Table 4.3.1 Côte d'Ivoire KP Layering Table: Comprehensive KP services across the HIV continuum

	Sex Workers	MSM	TG
Primary Individual Interventions	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening • SGBV screening • PrEP	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening • SGBV screening • PrEP	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening • SGBV screening • PrEP
Secondary Individual Interventions	• • Alcohol/drug harm reduction • Partner testing for sexual partners • PHDP • ART adherence support • STI Management • Viral load and other	• • Post-violence care • ART adherence support • PHDP • STI Management • Alcohol/drug harm reduction • TB screening and treatment • Partner testing for sexual partners • Viral load and other monitoring and investigative tests	• • Post-violence care • ART adherence support • PHDP • STI Management • Alcohol/drug harm reduction • TB screening and treatment • Partner testing for sexual partners • Viral load and other monitoring and investigative tests • U=U messaging

	monitoring and investigative tests • U=U messaging • TB screening and treatment • Disclosure of status to steady sexual partners/spouses • Post-violence care • Lubricants • OVC referrals for children of sex workers • Stigma and discrimination reduction • Mental health support	• Disclosure of status to steady sexual partners/spouses • Lubricants • Online outreach to reach hidden beneficiaries • Stigma and discrimination reduction • Mental health support • U=U messaging	• Disclosure of status to steady sexual partners/spouses • Lubricants • Online outreach to reach hidden beneficiaries • Stigma and discrimination reduction • Mental health support • Hormonotherapy interaction

In COP21, the KP program will provide dedicated programming for transgender (TG) people. The program will rely upon updated TG size estimates provided by the Global Fund/Alliance to set targets more accurately. In addition, the program will work closely with local CSOs with trans community support and service delivery competency to deliver a comprehensive package of services to TG beneficiaries.

The program will also leverage MSHP's updated policy on community ARV distribution to support KP continuity of treatment and adherence. The KP program will continue to ensure that young KPs and children of KPs are appropriately referred and linked to other appropriate services by closely collaborating, through MOUs, with OVC and DREAMS community programs. Close coordination among IPs will ensure that children of FSW access OVC and pediatric ART services, as needed. Likewise, the KP Program will collaborate with the DREAMS program to ensure young FSW aged 18 and older are screened and referred for relevant AGYW services, such as economic strengthening activities and provided post-GBV care. To mitigate stigma and discrimination, all IPs supporting clinical management of KP populations will offer comprehensive KP-focused health services, including sexually transmitted infections (STI) treatment, and psycho-social and GBV services.

The community-led monitoring system will be leveraged to ensure the delivery of quality services along the community and HIV clinical cascade continuum. This model will also ensure that index testing is implemented without coercion, including GBV prevention and response and addressing stigma and discrimination within the community. CSOs participating in community-led monitoring will report any concerns on quality of services and adverse experiences related to HIV care and treatment. Key Populations Implementing partners will be trained on Index testing services to ensure WHO recommendations on HIV testing and intimate partner violence considerations are well applied.

Across the PEPFAR-CI program, efforts will be intensified to build organizational capacity (e.g., monitoring and evaluation, financial oversight, HR systems, and management of contracts and sub-agreements) among KP sub-partners in the interests of sustainability and increased KP engagement in programmatic direction.

In COP21, the expansion of PrEP will continue across 127 clinical sites, including the 23 focused KP facilities, with an emphasis on key population groups who will benefit most from PrEP. The priority subgroups include all FSWs KPs with STI, KPs with high-risk sexual behavior such as irregular use of condoms, and sero-discordant couples when the HIV seropositive partner is not virally suppressed and/or in non-monogamous partnerships (including transgender individuals with the same characteristics). The PEPFAR-CI program will also intensify distribution of condoms and lubricants to KPs and their sexual partners through prevention and case finding platforms. Key barriers to PrEP uptake include diagnostic requirements (renal and liver function tests, etc.) and gaps in provider knowledge. PEPFAR-CI is working with PNLS to reduce barriers in line with WHO guidance, and through its IPs to ensure that health facility staff are familiar with and promoting PrEP for those at high risk of HIV acquisition.

PEPFAR-CI used national KP size estimation results of the Integrated Behavioral and Biological Survey (IBBS) funded by Global Fund/ PNLS in 2020 and triangulation exercise, which shows an estimated 75412 FSW and 49018 MSM in Cote d'Ivoire. PEPFAR zones will cover 66% and 63% respectively for FSW and MSM. Recent studies have highlighted KP HIV prevalence in 5 cities including for example the rural area of Abengourou with 11.3% for MSM. PEPFAR Key population Program will reinforce strategy based on epidemiological results.

The KP program shows key challenges to achieve epidemic control among these populations: TG people difficult to be reached, suboptimal elicitation and acceptance of index testing, inadequate VLC, and low uptake of PrEP. Challenges in VLC and VLS will be addressed by the involvement of community workers and strengthened partner management to ensure IPs improve patient flow, track available VL data and prioritize care and support for viremic individuals.

In COP21, the PEPFAR-CI KP program will target FSW who are difficult to reach and underserved in previous implementation periods, particularly those who work in remote areas around urban centers. The KP program will also continue to increase the engagement of 'maquis' (local restaurants) and hotel managers, pimps and 'queen mothers' of FSW by involving them in the program, sensitizing them and providing condoms and lubricants to promote contraceptive use by FSW.

During COP21, PEPFAR-CI will continue to support the GoCI in addressing human rights issues and institutional barriers in KP programming by extending training on stigma free service provision to health care workers and social workers in public health facilities. The KP sensitivity training will reinforce the capacity of health care workers in public health facilities and social workers to better provide KP-friendly and competent services. The LINK tool combined with ORA (online registration) will offer new options for KP to be tested.

The KP program will improve accessibility of viral load testing services to KPs through health care worker training in facilities, support sample transportation, and peer navigators to assist in

patient follow-up. Community workers will reinforce U=U messaging and viral load literacy to improve KP awareness in the community. Post counselling, PLHIV support groups to treatment and community ART distribution strategy will be developed to improve adherence to treatment and continuity of treatment.

4.4 Additional country-specific priorities listed in the COP21 planning level letter

Côte d'Ivoire specific priorities listed in the letter were addressed with the renewed and demonstrated commitment of the MSHP. As described in sections above, the program is prioritizing an accelerated transition to DTG-based regimens, particularly among children and women of childbearing potential in order to achieve long-term VLS. In addition to routine site-level mentorship, collaboration with the OVC program for caregiver support, and facility-based HRH support for PMTCT and pediatric case management, in COP21, PEPFAR CI will collaborate with PNLS to provide focused and intensified TLD/MMD workshops including physicians and district/regional MSHP leadership. This is critical to answer questions, address concerns, and ensure buy-in from the nation's clinical leadership in the program's ongoing efforts to deliver client-centered care in the COVID-19 era, and to improve VLS and survival through optimal treatment. Case finding strategies have been described above and modalities will be calibrated to the needs of sub-populations, with a focus on efficiency. Finally, all aspects of partner management will be strengthened, including data quality and integrity, oversight of sub-grantees, and appropriate deployment of HRH to improve performance. These efforts will be complemented by focused investments to improve health information systems at central and site-levels to improve data quality across the cascade of HIV services.

4.5 Commodities

The COVID-19 pandemic continued to hinder the supply chain operations, both at global and national levels, creating stock tensions and sometimes shortages in health commodities. The most affected commodities are lab commodities, in general, and VL reagents specifically. Shipments Lead Time and freight cost increased significantly, creating stockouts and gaps in commodity budget. In COP21, mitigation measures will be applied to avoid impact of delays in delivery of key commodities and potential freight cost increase. This will include an early placement of orders and leveraging ARPA funds to compensate for the extra costs.

Regarding the FY2022 HIV commodity funding landscape, PEPFAR-CI and the GF will continue to be the main external donors, and the GoCI will continue to increase its contribution. In order to avoid any duplication in resource allocation, GoCI, GF, and PEPFAR-CI, WHO, and UNAIDS are committed to fully coordinate their planning processes, including the annual quantification and quarterly supply planning exercises, and monthly stock analysis. PEPFAR-CI's COP21 total of $7.4M budget for commodities has been developed under a number of assumptions: the GF contribution for HIV commodities will be around $11.7M based on GF's New Funding Model (NFM3); and the GoCI will contribute for the rest, for approximately $19M for procurement of HIV commodities based on its 2022 HIV commodities supply plan. During the COP19 and COP20, PEPFAR has been procuring the committed quantity of commodities, regardless of the level of achievement of the program targets. This situation has generated big pipelines in key commodities that can be considered as savings on the commodities budget. Also, COP21

coincides with the reduction of Spectrum estimates of the number of PLHIV for Côte d'Ivoire. This explains the drastic reduction of the contribution of PEPFAR on commodity budget. During the COP21 planning process, PEPFAR has had a continuous conversation with the GoCI, the Global Fund and other key stakeholders to make sure the commodities procured are aligned with the national Program and PEPFAR priorities. For COP21, the focus will be put on TLD multi-month bottles to support and boost the newly scaled MMD policy, and the newly introduced pediatric optimized ARV, DTG-10, to improve VLS outcome in children. PEPFAR will also prioritize the VL and EID POC reagents and consumables which have been highly impacted by frequent stock outs.

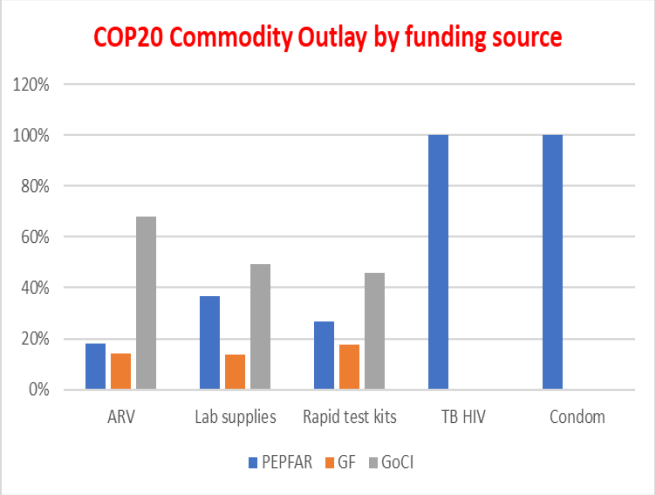
The COP21 budget for commodities was developed to complement the national needs for commodities, contributing to the common basket for supplies. Table 4.5.1 below summarizes the proposed approximate percentage of allocations of items by category and by funding sources.

Table 4.5.1 COP20 Commodities Outlay by Funding Source

The COP21 budget for commodities was developed to complement the national needs for commodities, contributing to the common basket for supplies. Table 4.5.1 below summarizes the proposed approximate percentage of allocations of items by category and by funding sources.

Table 4.5.1 COP20 Communities Outlay by Funding Source

Commodity Outlay by funding source			
	PEPFAR	GF	GoCI
ARV	18%	14%	68%
Lab supplies	37%	14%	50%
Rapid test kits	27%	18%	46%
TB HIV	100%	0%	0%
Condom	100%	0%	0%



The majority of COP21 commodities have been budgeted for procurement through the GHSC-Procurement Programs, except for a very small amount attributed to very specific lab items which have been budgeted under the Local Health Supply Procurement and Logistic Activity (LHSPLA), CDI Local Procurement and Supply Chain TA provider mechanism.

Procurement of Tenofovir+Lamivudine+Dolutegravir (TLD) as the preferred first-line drug for ART

On a programmatic level, PEPFAR-CI's budget for commodities will be used primarily to partially fund the procurement of optimized ART regimens. PEPFAR will continue to procure first line ARV drugs for adults (TLD). The CSOs and their members have expressed concerns

regarding dispensing/using TLD packs of 180 count, therefore COP21 funds will be used to support procurement of TLD bottles of 90 count. As we move forward transitioning PLHIV from TLE to TLD, we have observed a large quantity of TLE400 pending orders, and a conversation with the GoCI/GF is ongoing to change some of those TLE orders to TLD.

The TLD transition has made significant progress during COP20 implementation: from around 30% in June 2020, data from PEPFAR supported sites shows that 61% of TX_CURR are on TLD as of March 2021. The plan is to transition 90% of all TX_CURR on TLD by December 31st, 2021. During the COP21 planning meetings with stakeholders, the PNLS emphasized that due to intolerance and contraindications, at least 10% of adult patients would remain on TLE. The supply planning process was conducted according to those assumptions. The upcoming supply plans review will be an opportunity to update the targets and outcomes, based on actual programmatic results. This big jump was allowed by the issuance by the implementation of the new circular issued by the MOH on April 14th, 2020 to update the current policy to extend Tenofovir+Lamivudine+Dolutegravir (TLD) and DTG-based regimens to all HIV-positive adults, including women of childbearing potential, and children >=20 kg.

Figure 4.5.1 below shows the TLD uptake in Côte d'Ivoire from Oct 2019 to March 2021.

Figure 4.5.1 TLD uptake trend over time

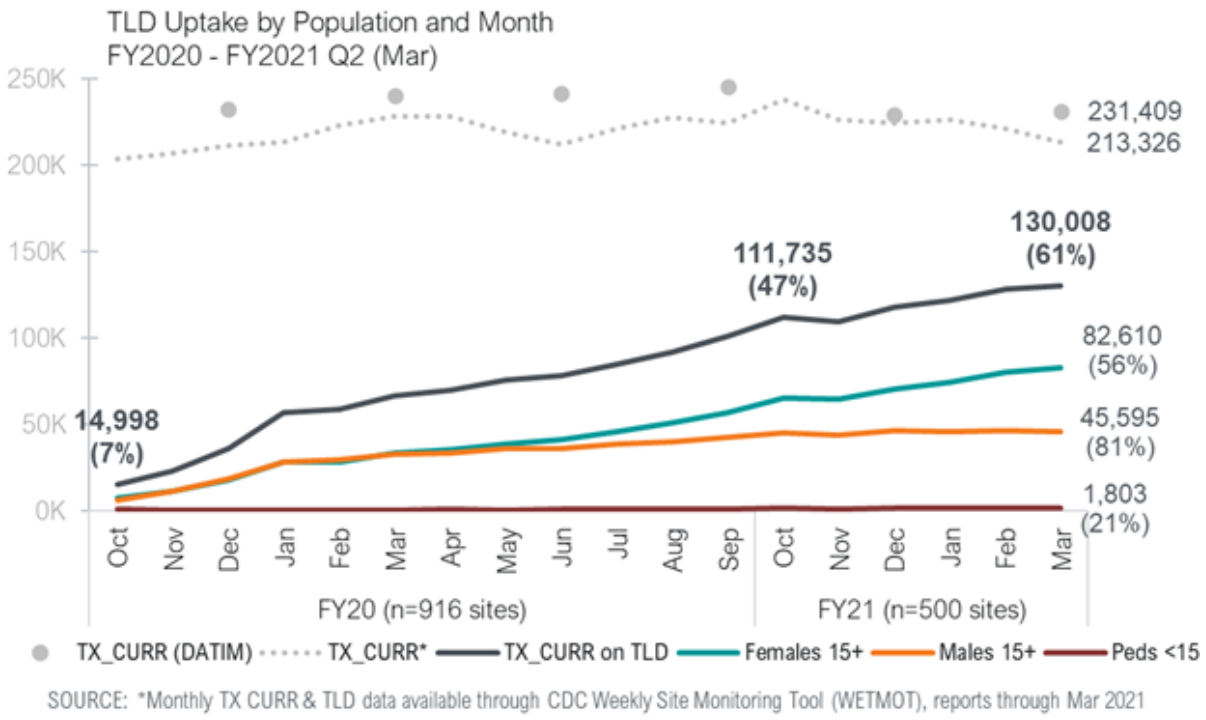
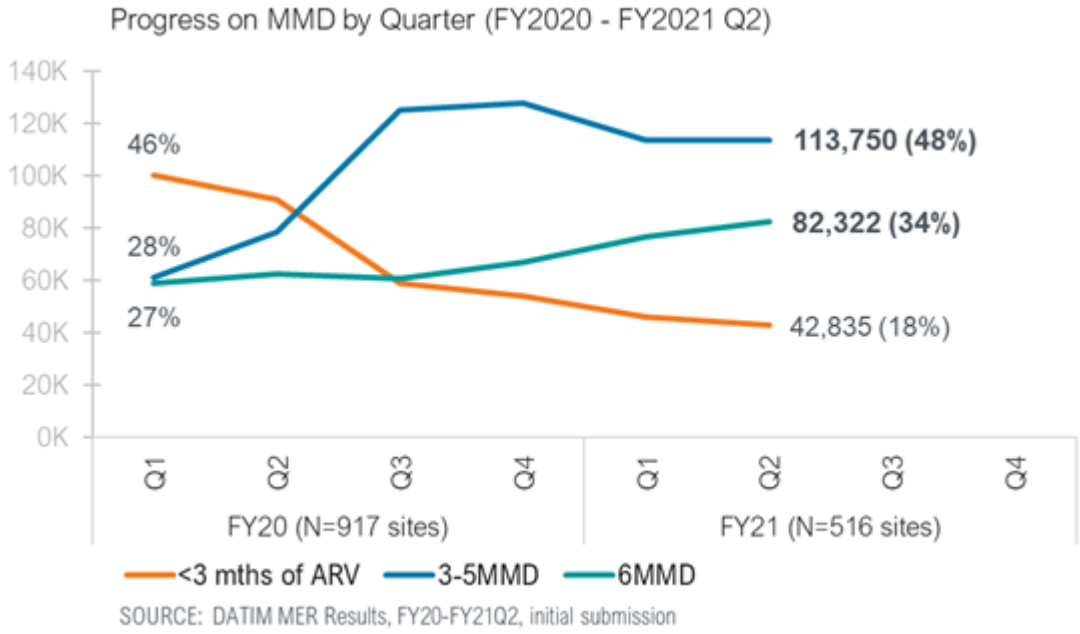


Figure 4.5.2 below shows the MMD progress in Côte d'Ivoire from Oct 2019 to Mar 2021.

Figure 4.5.2 MMD progress trend over time



Optimization of Pediatric ART

New pediatric dosage of DTG for <20 kg children, DTG 10 mg, is now available for procurement by PEPFAR. The goal is to transition all children on DTG-10, starting with those on NNIRT (NVP and EFV). The target is to switch 90% of peds on DTG-10, and the remaining 10% should be on LPV/r 40/10 pellets or granules. The first delivery of 7,700 bottles of DTG-10 was received in CDI in April 2021, and PEPFAR-CI has committed to procure 100% of the DTG-10 needed to ensure the implementation of pediatric optimized regimens is completed by September 30th, 2022.[OBJ]

Procurement of Tenofovir/Lamivudine for PrEP

During FY22 PEPFAR-CI will not procure ARVs for PrEP because the existing quantities procured in COP20 are sufficient to cover COP21 needs.

Procurement of drugs for treatment of cryptococcal meningitis

In COP21, PEPFAR-CI will not procure prophylaxis or treatment for cryptococcal meningitis because the existing stocks and pending orders are more than sufficient to cover all the needs for COP21.

Procurement of diagnostics and TPT

Existing stocks and pending orders are sufficient to cover all the needs in TB and Advanced HIV Disease diagnostics and treatments. Therefore, PEPFAR will not procure those commodities in COP21.

Procurement of condoms and lubricants

In COP21, PEPFAR-CI investments will be used to fund procurement and the distribution of 16.5 million male condoms, 650,000 female condoms, and 545,000 units of lubricants, with support from the COP21 Condom Procurement Fund. Condoms will be stored at central medical stores (NPSP) and distributed through district approach by local NGOs.

4.6 Collaboration, Integration and Monitoring

4.6.1 Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including the GF and MSHP

PEPFAR-CI's strategic vision is to help align PEPFAR and all other bilateral and multilateral support behind a national strategy led by the Government of Côte d'Ivoire. Throughout FY21 thus far, PEPFAR-CI has successfully maintained and strengthened effective collaboration with all key stakeholders, including the Ministry of Health and Public Hygiene (MSHP), the Ministry of Defense (MOD), the GF, WHO, UNAIDS, and CSOs on all aspects of program implementation and results achievement. This active collaboration has resulted in a more substantial involvement of these major players in the COP21 planning process. PEPFAR-CI intends to continue this close and effective collaboration through quarterly sharing and review of performance data, including best practices and programmatic challenges, joint planning and sites visits, and joint monitoring of policy implementation.

The DGS will continue to lead coordination efforts in collaboration with the PNLS and the National OVC Program (PNOEV). This approach will contribute to the MSHP overall vision to ensure the sustainability of the national HIV/AIDS response by generating synergies across player, including decentralized authorities (elected or appointed) who will be held increasingly accountable for the oversight of HIV/AIDS activities at regional and district levels.

Since COP19, PEPFAR-CI has been supporting a Joint Monitoring Plan, under the leadership of the DGS and technical oversight of the PNLS. The plan brings together all key holders including donors, CSOs, Region Presidents, Préfets, Sous-Préfets, and regional and district health officials under a joint framework for planning and reviewing the performance of the program. Despite challenges linked to national political agenda and then to the COVID-19 epidemic, this plan has helped raise awareness at decentralized levels with more accountability from region and district health directors on program performance. Specific indicators routinely monitored include treatment interruption, TLD transition, TPT scale up, and achievement of the 95-95-95 goals.

PEPFAR-CI will continue to support this Joint Monitoring Plan at three levels:

- At the national level, through increased focus on data utilization for decision making, including monthly performance data reviews led by the DGS, quarterly performance reviews led by minister, regular field supervision, and semi-annual review of performance with other stakeholders. The PEPFAR-CI team will also support the MSHP in the development of policy documents, guidelines, standard operating procedures as well as their implementation to reflect agreed-upon shifts in the national program to accelerate achievement of the 95-95-95 goals.

- At the decentralized level, through active oversight by Regional Health Directors and District Health Directors including real time engagement of decentralized authorities (regions and autonomous districts) as a way to facilitate involvement of community-level players.
- At site level, support to collegial accountability of health facilities and community actors, with CSOs playing an active role in monitoring implementation of policies will help improve site-level programmatic challenges, especially the improved ability to find new cases among targeted groups, link them to treatment, retain them in care and keep them virally suppressed. COP21 will continue to strengthen community-facility collaboration using the "Collaborative Monitoring Matrix" developed under COP20, including intermediary indicators that show the level of community and facility collaboration as well as outcomes indicators that demonstrate HIV outcomes. PEPFAR-CI, GF and other key partners will also continue to support the MSHP in the systematic review and triangulation of patient level care and treatment outcome with key monitoring strategies such as supervision and coaching provided by regional and district health teams, decentralized authorities response to specific challenges, and community mobilization actions to expand specific program components.

The goal of these multi-level collaboration efforts is to help improve data use for program performance and to boost the MSHP capacity for data governance in the national HIV response.

4.6.2. Strengthening IP management and monitoring and the implementation of innovative strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods

Based on the performance gaps identified during the COP19 implementation period, PEPFAR-CI has developed and enforced monitoring plans by IP, based on specific gaps by district, to improve case finding, reduce IIT and improve linkage and continuity of treatment.

In COP21, all USG agencies will prioritize partner management for achieving results. There will be – at a minimum - monthly monitoring of prioritized sites by USG, IPs, and MSHP, focusing on critical gaps in achieving improvements in quality and patient-centered services including continuity of treatment, lost to follow-up, data quality, as well as monitoring of policy roll out (TLD, MMD, TPT, and elimination of user fees) to ensure effective implementation. The USG team will ensure weekly data collection of site level data and monthly reviews to identify high performing sites where best practices can be rapidly identified and scaled as well as rapidly identifying and addressing any issues related to the quality of services or IP performance identified. PCO-led interagency site-visits will continue as needed, in order to address issues of data integrity with community HTS and linkage to care. Continued use of the interagency technical working groups (TWG) as a platform for data-driven decision making; the TWG will facilitate rapid and standardized review of key indicators (both MER and custom indicators) across the cascade as well as IP expenditures to ensure that PEPFAR investments are achieving targets and their impact on PLHIV. Implementing Partners will leverage and build upon best practices to scale up priority interventions.

PEPFAR-CI will support appropriate increase of human resources within the GoCI to implement joint monitoring, including the exploration of the use of Performance-Based Funding (PBF)

resources from the World Bank to help address critical gaps at district level through site-level recognition and also improve oversight and quality of HIV service delivery with a special focus on TA sites.

As a result of granular site management (GSM) and other data-driven initiatives, PEPFAR-CI has more clarity on the specific gaps at sites and has moved into the next phase of closing those gaps by working closely with the IPs to address the different issues along with developing plans to roll out differentiated approaches and solutions depending on need and in collaboration with the MSHP. Consistently underperforming sites will be subject to focused monitoring by the site management team (MSHP, CSO and USG staff), to rapidly address performance gaps.

As part of civil society engagement in the HIV response, in COP21, PEPFAR-CI will expand community-led monitoring with civil society organizations/ network and UNAIDS will administer the program and provide technical assistance. Local community groups will be engaged in the planning, implementation, and refinement of these community monitoring platforms. Community monitoring mechanisms will be action-oriented and routine. Specific metrics will be tailored to a given context, including specific needs and concerns of community members. That mechanism will provide routinely information back to PEPFAR and GoCI. Moreover, increased community engagement will occur with faith-based institutions through the FCI program.

4.6.3 Improving integration of key health system interventions, including HRH and laboratory (VL) activities across the cascade.

The PEPFAR-CI HRH strategy in COP21 aims to continue to provide support for human resources for health to strengthen implementation along the clinical cascade, at both facility and community levels. In COP21, PEPFAR-CI will continue to support staff at high impact and moderate impact facilities and surrounding catchment communities as needed to ensure high-quality, patient-centered services.

PEPFAR-CI has begun monitoring the allocation, productivity, and impact of HRH by linking staffing changes to relevant facility and community performance, and this data was foundational in developing budget assumptions for COP21. This increased rigor and granularity will continue to benefit PEPFAR CI's programming in the years to come.

Community cadres will be responsible for community-based case finding, ensuring all patients found positive are properly counseled and linked to treatment, tracing all defaulters, supporting patients who are at risk of missing an appointment, and making sure patients who are eligible for viral load testing return to the clinic for their tests. PEPFAR-CI is constantly analyzing workforce requirements for the maintenance of HIV services in consultation with implementing partners. The serves as the basis for formal dialogue with the MSHP and other stakeholders on greater shared responsibility of HRH requirements and as part of domestic resource mobilization efforts for HIV. In addition, PEPFAR-CI continues to work assiduously with the MSHP on the definition and standardization of responsibilities and remuneration for community health workers within the framework of the National HIV response and the

National Health Development Plan (PNDS 2016-2020). Finally, this analysis underpins the design and implementation of effective strategies to accelerate programmatic progress.

To address challenges with the third 95 of the clinical cascades, PEPFAR-CI is introducing numerous measures to drastically improve VL uptake and increase viral suppression rates. These changes/interventions include training health care and community health workers with on-site coaching, supervision, and competency assessments for lab professionals; provision of performance-based financing to improve lab staff continuity of treatment; effective utilization of VL testing dashboards to fast track unsuppressed VL with emphasis on children, adolescents and men and to document clinical site and laboratory performance; improving the laboratory information system to collect data on VL uptake and real time data analysis; strengthening capacity for OVC staff to track VLC/VLS and communicate the families they support; and clinical HRH support (VL champions). Programs and district health teams will be responsible for developing and implementing effective policies, planning, HRH, and real time monitoring of patient data. Packages of activities are defined for IPs to support the district heath teams, provide resources for registers, training materials, transportation and improve turnaround time for VL results. Lab mapping to optimize VL lab network and improve laboratory clinical interface will continue. Facility and community IPs will receive adequate resources and staff for optimal management of patients to improve VL suppression, reduce mortality, and reduce lost to follow-up.

4.6.4 Improving quality and efficiencies of service delivery through improved models of care delivery across community and facility sites;

Community-facility collaboration has been described extensively in previous sections, with clearly defined roles and responsibilities for each throughout the cascade. MOUs and monitoring frameworks will continue to be utilized as described. In COP21, additional efficiencies will be obtained through granular and evidence-based HRH assumptions. Facility HRH assumptions will be based upon ongoing acceleration of MMD for eligible patients (reducing the frequency of clinical visits), patient volume and growth by site, and MSHP-supported staff presence. Community-based HRH assumptions are based upon program data quantifying the sub-populations actually in need, the frequency of home visits, and the staff complement required to achieve high-quality yet efficient services. Improvements in data management (UPID, SIGDEP upgrades/expansion, and CommCare) will also contribute to efficiency by reducing data duplication and irregularities.

4.6.5 Use of unique identifiers across sites and programs in clinical settings

In COP18 (FY2019), PEPFAR-CI collaborated with MSHP to approve the concept to use securely encrypted numeric code (based on fingerprint) to constitute a unique patient identification code (UPID) to be used for all PLHIVs and TB patients across all programs (e.g., HTC, ART, PMTCT, Lab) to address Côte d'Ivoire's systemic program linkage, interruptions to treatment, and data quality issues. In COP19 (FY2020), the UPID was fully integrated into Côte d'Ivoire's HIS architecture and the site-level solution was developed and tested with the national EMR (SIGDEP2). The initial rollout phase, however, was delayed in FY2020 due to COVID 19 health restrictions. As of May 2021, the UPID solution has been implemented in 10 initial sites and integrated with the site-level EMR (SIGDEP2) to assess acceptability and effectiveness of the

solution. By the end of COP20 (FY2021), the UPID solution will be scaled up and deployed to 138 of the highest volume high impact sites. COP20 activities are also upgrading SIGDEP2 to modern architecture (OpenMRS 2.3) to prepare interoperability between this system, OpenELIS (lab information system), and the UPID solution.

In COP21, through ARPA and Ambition funds, PEPFAR Côte d'Ivoire will accelerate UPID implementation along with an updated EMR (SIGDEP3) starting with all 172 high impact sites, which support approximately 70% of active patients on treatment. In addition, to complete a national-level UPID system requires a central Patient Identity Management solution to deduplicate and manage patients across individual sites and eventually all testing locations, including those patients who require alternative UPID when fingerprints cannot be used. In COP21, MSHP will receive technical assistance to gather requirements and develop a Patient Identity Management system that will be flexible to adapt and integrate with the planned national-level unique identification once implemented by GoCI. In addition, The expected outcomes are:

- Maintenance, support, and improvement to the existing UPID system
- Deployment of UPID site-level solution to 34 remaining high impact sites and SIGDEP 3.0 to all 172 high impact sites
- Develop a Patient Identity Management system to manage unique ID, patient identity, and deduplicate patients, including those who have no fingerprints, in alignment with existing systems and based on international standards (opensource software, data exchange standards)
- Requirements gathering and initial development of UPID module to include enrolment of patients at point of testing

4.6 Targets by population

Table 4.6.1. ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Estimated current on ART (FY21)	Additional patients required for 90% ART coverage	Target current on ART (FY22) *TX_CURR*	Newly initiated (FY22) *TX_NEW*	ART Coverage (FY22)
Attained						
Scale-Up Saturation	**330,560**	**245,364[1] (91%) 268,799[2]**	**28,705**	**270,710[1]**	**30,977[1]**	**89%[3]**
Scale-Up Aggressive						
Sustained						
Military		**4,854**		**5,590**	**875**	
Not PEPFAR Supported	**40,116**	**26,709**	**9,395**			
Central Support						
TOTAL	**370,676**	**250,218[1] (85%)**	**38,100**	**276,300[1]**	**31,852[1]**	**88%[4]**

Prioritization Area	Total PLHIV	Estimated current on ART (FY21)	Additional patients required for 90% ART coverage	Target current on ART (FY22) *TX_CURR*	Newly initiated (FY22) *TX_NEW*	ART Coverage (FY22)
		295,508[2]				

1. Results include only those supported by PEPFAR

2. Results include PEPFAR and those supported by MSHP (estimated 23,435 in Scale-Up Saturation SNUs; 50,144 total at end of FY21)

3. Includes 23,435 estimated TX CURR supported by MSHP sites in Scale-Up Saturation SNUs (9% of total)

4. Includes 50,144 estimated TX CURR to supported by MSHP (15% of total)

Table 4.6.2. Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (SNUs) and disease burden	FY22 Target (%)
AGYW	267,739	42,761 (16%)
PP_PREV	229,546	149,205 (65%)
KP_PREV	80,901	36,277 (45%)
TOTAL	**578,186**	**227,266**

Table 4.6.3. Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY22 Target) OVC_SERV (<18)	Target # of active OVC (FY22 Target) OVC_SERV (<18, 18+)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY22 Target) OVC*
Abengourou	8,249	1,949	2,459	2,165
Abobo-Est	15,601	6,471	9,752	7,191
Abobo-Ouest	17,775	3,203	4,008	3,560
Adjame-Plateau-Attecoube	16,795	7,894	9,904	8,771
Adzope	3,482	1,551	1,947	1,725
Agboville	5,144	2,515	3,160	2,795
Akoupe	2,198	1,406	1,763	1,563
Anyama	3,679	1,790	2,244	1,988
Bangolo	3,701	1,705	2,137	1,895
Bondoukou	6,958	4,073	5,101	4,527
Bongouanou	3,625	3,619	4,536	4,021
Bouafle	6,593	1,990	2,513	2,213
Bouake-Nord-Est	3,692	2,578	3,235	2,864
Bouake-Nord-Ouest	7,515	4,588	5,731	5,097

Bouake-Sud	6,305	2,734	3,430	3,038
Cocody-Bingerville	15,124	7,425	10,227	8,251
Dabou	5,386	1,711	2,148	1,902
Daloa	11,672	6,163	8,523	6,849
Divo	6,226	6,004	7,521	6,672
Duekoue	5,429	3,616	4,538	4,018
Gagnoa 1	7,312	3,586	4,508	3,986
Guiglo	2,935	2,660	3,344	2,958
Issia	5,048	1,448	1,820	1,609
Korhogo 1	10,217	5,797	7,291	6,442
Koumassi	11,228	2,611	3,292	2,901
Man	7,656	3,568	5,046	3,967
Mankono	2,672	453	569	505
Oume	5,193	1,789	2,249	1,987
Port-Bouet-Vridi	10,949	4,934	6,194	5,483
San-Pedro	11,042	3,419	4,296	3,800
Sinfra	4,625	2,153	2,697	2,394
Soubre	8,775	2,773	3,482	3,080
Tabou	2,639	442	553	493
Tanda	2,582	3,920	4,910	4,356
Tiassale	4,189	2,482	3,113	2,758
Treichville-Marcory	22,455	3,893	4,864	4,327
Yamoussoukro	8,055	2,265	2,843	2,516
Yopougon-Est	19,972	3,380	4,271	3,757
Yopougon-Ouest-Songon	21,062	3,482	4,402	3,868
TOTAL	**323,755**	**128,040**	**164,621**	**142,292**

4.7 Viral Load and Early Infant Diagnosis Optimization

FY20 has seen an expansion of VL coverage (VLC) from 67% in Fy17 to 84%, and an improvement of VL suppression (VLS) from 70% to 87% among PLHIV in Côte d'Ivoire's PEPFAR-supported districts. Despite this overall improvement, the program still has weakness in coverage rates in 22 of the 79 prioritized districts. Detailed analysis of VLC and VLS suppression have shown gaps in sub populations including KP, pregnant and breastfeeding women, young adults aged 20-29, and children aged 0-4. In response to these challenges, PEPFAR-CI has developed an innovative approach for program and clinical IP management. This includes the use of DBS for hard-to-reach sub populations such as KP and children, remote locations, and during afterhours or weekends in clinical sites. Community lay counselors will be trained on DBS collection for difficult to reach children and KP. To improve the turnaround time and the results return among these populations, an SMS system will be implemented.

In order to achieve epidemic control by reaching 96% coverage and 95% suppression by September 2022, PEPFAR-CI will focus on the 455 high impact and moderate impact clinical sites, including 235 pediatric sites (expansion from 95) with CLHIV cohorts of >10 patients, for improvement. The low impact sites receiving PEPFAR support will have a technical assistance model with no additional human resource support; these sites will, however, be linked to nearby

high impact and moderate impact sites, thereby benefiting from those investments. The FY19 surge plan defined the path by identifying key and innovative strategies, such as home blood collection, after hours services, blood collection and laboratory shift hours and weekend testing, and partner management solutions for closing the gap. The PEPFAR in-country team defined indicators across the clinical cascade, including the lay worker: patient ratio. Weekly targets for VL coverage and suppression were set by partners, such as the number of blood samples to collect and the number of patients requiring enhanced adherence counseling (EAC). This has resulted in 91% coverage and 83% suppression at the 139 priority sites (as designated in COP 19). Since Q2 COP18, PEPFAR-CI supported the development and implementation of an electronic tool to monitor VL appointments and follow-up with unsuppressed patients and enroll them in enhanced adherence counseling. The electronic tool is being used by clinical IPs to generate weekly reports and has shown higher VLC and VLS rates at 91% and 83% respectively, compared to 72% and 79% at non- prioritized sites.

During COP21, IPs will continue to implement and expand strategies and practices that have been demonstrated to improve VLC and VLS. These strategies include extended operating hours at clinical sites for consultation and blood draws during weekends and evenings after work; home blood draws and transportation for patients with physical disabilities; improved patient flow by combining appointments for ARV pick up with VL testing; and prioritization of children and PBFW by maximizing opportunities for VL testing at routine visits, and by proactively tracking these cohorts, alerting patients and providers when tests are due, and following up on results for decision-making. Additional strategies for improving VLC include dedicated VL testing days with fast-track patient circuits at the facility or nearest satellite lab, and additional HRH for VL collection. Dedicated clinical and community lay counselors will be recruited and strategically placed at key sites based on demonstrated gaps and patient needs. Their roles are to remind patients of appointments, collect any relevant information that will help improve patients' adherence to treatment and reduce loss to follow-up, and share the list of non-reachable patients with community IPs to initiate home visits. These strategies will be implemented at the maximum possible number of PEPFAR-supported sites, calibrated to their specific needs and within existing budget constraints. Progress will be monitored every week using the VL/EAC electronic tools. IPs will be monitored on a weekly basis with coaching and visits to sites with the poorest performance by PNLS and district health teams, and close monitoring to improve indicators. IPs with poor performance after 3 months of implementation of the surge plan will be put on performance improvement plans. The goal for PEPFAR-supported sites will be to reach 96% coverage and 95% suppression by September 2022.

1. strategies for TB/HIV integration and optimization of existing POC and conventional instrument capacities

Using funds from the American Rescue Plan Act (ARPA) PEPFAR-CI will conduct a comprehensive Diagnostic Network Optimization exercise which aims to align and harmonize objectives and approach among all stakeholders, better align testing demand and capacity, and ensure each instrument plays its role within the network. This exercise will ensure that the pressure and impact of COVID on the lab system does not overwhelm or impede HIV program diagnostic capacity.

The two well organized TB GeneXpert and VL/EID HIV laboratory networks will be integrated and optimized in order to improve access to laboratory services for PLHIV. The existing Laboratory Information System (OpenELIS) will be improved to reduce sample TAT, as well as investments to build the laboratory-clinical interface. The system will have the required annual security upgrade to comply with international guidelines to enable secure access to the system and protect patient records. The Lab information System will also be upgraded for interoperability with patient EMR SIGDEP2. All these upgrades aim to reduce laboratory turnaround time by introducing electronic VL/EID and TB demand and result return to clinical and community sites.

As per the agreement signed with ROCHE in COP 19, all the Cobas Taqman machines are being replaced since COP 20 by Cobas 4800. In COP 20, 10 Cobas 4800 have been delivered and are being installed. In COP21 the remaining 9 machines will be replaced.

2. Projected new sites or geographic areas in FY21 for EID and VL among PBFW only

Project UNITAID and MSHP have implemented POC EID testing at 27 PMTCT sites. PEPFAR has worked closely with MSHP to develop a national VL/EID POC testing policy and will extend the project to 60 high volume PMTCT sites. The goal is to reach 60% of EID and 25 % of VL for PBFW with POC testing, using a hub and spoke model. Additional strategies such as community EID testing and testing at other entry points such as vaccination and nutrition centers will help improve VL and EID coverage for mother-baby dyads. In FY22, optimization of the network will be done through community VL/EID testing with the goal to reduce TAT to a maximum of 24 hours.

3. Proposed activities to improve Viral Load Coverage and Suppression and TB testing

The 7 clinical implementing partners' (ARIEL, EGPAF, ICAP, HAI, SEVCI, ACONDA, EpiC) funding packages include costs associated with laboratory service such as sample transportation, training, and coaching /supervision to ensure patients' access to VL/EID.

Funding for the TBD mechanism will support the existing VL laboratory infrastructure, account for minimal procurements to implement the SMS project for results notification, and to develop procedures for the national sample transportation system that will be done in collaboration with the Global Fund.

To accelerate progress on the 3rd 95, COP funds will support OPENLIS, which is critical to improve VLC and VLS data quality, reduce turnaround time, and maintain patient confidentiality. COP21 support will also include continuous quality management for HIV testing to ensure accurate results.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Through SID 3.0, MILSID, MER, SIMS and Granular Site Management visits, PEPFAR-CI has identified seven (7) key system barriers that prevent it from fully achieving its objectives. To

address these barriers, most of the systems level investments support activities to strengthen and enable an environment for quality service delivery.

The proposed activities are related to SID 3.0 elements with the objectives to: i) improve availability of quality and timely OVC and DREAMS data collection, tracking, ad monitoring of the primary, secondary, and contextual DREAMS services and increase PrEP awareness and uptake, ii) increase demand for HIV services and coverage among men including self-testing, iii) effect rapid ART distribution of TLD for all PLHIV, iv) decrease HIV morbidity and mortality, and improve VL coverage and availability of results, v) improve data quality to better assess and improve linkage and continuity of treatment, vi) reduce HIV-related stigma and discrimination against KP and PLHIV, vii) work with existing platforms to assess, establish a national QI plan, and strengthen clinical quality management structures and implement CQI approaches to improve the quality of service delivery at supported sites. In addition, PEPFAR-CI will collaborate with the MSHP to leverage multi-stakeholder data reviews to focus interventions on sites and program areas lagging behind; performance-based financing will be implemented at selected prioritized sites to accelerate progress in critical areas such as case finding, continuity of treatment and viral load suppression for adolescents and children; case finding for men and women; and continuity of treatment of young adults.

These objectives and their corresponding above-site activities provide the foundation for the site-level, service delivery interventions supported through PEPFAR-CI. All planned activities work together toward sustained epidemic control.

1) Stigma and Discrimination

During FY2021, PEPFAR-CI will design and implement a program to reduce stigma and improve HIV and treatment literacy through the local network of faith and community leaders, following the Faith in Communities Initiatives (FCI) model. Starting in high burden areas in Abidjan, this activity will use materials and successful interventions from other FCI countries and adapt them to the Ivorian context. The intervention will include mapping of faith and community structures; workshops and trainings with faith and community leaders; material production; and supervision and ongoing support for roll out in four select, high-burden districts.

2) Laboratory

During FY2022, PEPFAR-CI will continue to focus on addressing the challenges and weaknesses identified during FY 2020 and 2021:

- Insufficient laboratory and clinical interface for HIV, TB and OIs results utilization for better patient management
- Weak maintenance of laboratory equipment
- Delays in sample processing due to weak human resources
- VL/EID results long turnaround time

To address the aforementioned challenges, in FY22, PEPFAR-CI will extend the existing Lab Information System (LIS) OpenELIS to TB diagnostic laboratory network. This should result in

reducing laboratory results TAT and improve laboratory-clinical interface. Required annual security upgrades of the OpenELIS will also be implemented to comply with international guidelines to enable a secure access to the system and protect patient records. In addition, the OpenELIS will be upgraded to improve the interface between patients' medical results and the VL, EID and TB lab, these upgrades will be made to the LIS for interoperability with the patients' electronic medical record (EMR) SIGDEP. PEPFAR-CI would also continue to support lab staff capacity building as well as targeted strategic support for lab equipment maintenance not covered by warranties.

In addition to addressing the challenges above, PEPFAR-CI would carry out advocacy with the MSHP and Global Fund for the development of an integrated sample transport system as well as provide funding for TA and development of SOPs for the system.

3) Supply chain

Supply chain strengthening interventions in FY2022 will continue to contribute to bolstering health systems for quality control, monitoring and real-time response.

Building on the prior year achievements in this area, PEPFAR-CI investments focus on support to: implement commodity data collection plan (in compliance with SGAC's new data requirement, PPMR-HIV, TLD and MMD indicators); development of logistics management and reporting tools (inventory, reporting, tools) to hep ARVs distribution by CHWs; implement ARVs distribution by CHWs (inventory, reporting, tools) management and reporting; update SOPs and LMIS to include community ARVs distribution; production and use of logistics data to inform decision making for increased availability of communities at service delivery points; and expand implementation and maintain electronic logistics management information system for health to 26 new health districts. Concurrently, these activities will assure improved coordination among stakeholders and increased ownership by local institutions of supply chain processes.

TBD Last Mile Mechanism key activities:

· Improve ownership of supply chain functions by Regional Pharmacists.

· Support stock inventory monitoring at facilities within the supported regions and districts.

· Support supported districts and clinical partners for monthly data triangulation exercises to cross-check logistics and service data (TX_CURR vs SC_CURR; TLD uptake, 6MMD and VLC) to ensure discrepancies are addressed earlier.

· Support for last mile logistics (transport and distribution, and stock transfers across sites to resolve timely any stockouts) within the supported regions/districts.

· Coordinate with other USG IPs to track issues related to supply chain functions within the supported regions/districts.

· Work with the Community IPs to improve the community ARVs distribution monitoring.

· Ensure supply chain and logistics support for community ARV distribution in alignment with program orientation (home-delivery and community adherence groups).

4) OVC/DREAMS

In COP21, PEPFAR will continue to develop and disseminate OVC/DREAMS tools (case management, report templates, screening tools, etc.); Revise and adapt OVC/DREAMS database to include new requirements (age band, eligibility criteria, unique identifier for beneficiaries, improved needs analysis); Strengthen and ensure full functionality of OVC/DREAMS database for fast-tracking of OVC services and accurate reporting of DREAMS layering; and complete full transition of the OVC/DREAMS database to PNOEV.

The complete full transition of the OVC/DREAMS database to PNOEV lead by DFI/MEASURE, scheduled for COP21 will include the following key actions which remain to be completed: i) achieve inter-operability (synchronization of the two DREAMS and OVC databases in one); ii) Upgrade the database to adjust data from both DREAMS and OVC beneficiaries; iii) ensure the maintenance costs related to the DREAMS and OVC server; iv) ensure the deployment of the application on all sites at the national level.

5) PrEP

During COP21, PEPFAR CI will focus on addressing the key challenges: i) low demand creation; ii) policy barriers that mandate HBSAg and creatinine testing prior to PrEP initiation, though this is not in line with WHO guidance; iii) lack of availability of HBSAg and creatinine tests at site level; and iv) recurrent failure of laboratory machines on certain sites. A remediation plan is being implemented to address the current challenges. PEPFAR CI continues to work with PNLS towards revising national PrEP guidelines to harmonize them with WHO guidelines, eliminating the barrier of HBSAg and creatinine testing prior to PrEP initiation. During COP21, PEPFAR CI will work closely with the MoH/PNLS to remove the political barrier that limits the prescribing of PrEP only by accredited physicians and extend the delegation of tasks to other health providers such as nurses and midwives. This is in line with the goal of expanding client-centered services, including in community settings, and accordingly, PEPFAR CI will advocate for PrEP (as is the case with ART) to prescribed on a multi-month basis.

For COP21, the strategic vision for PrEP is based primarily on 3 key priorities including increasing demand creation, improving PrEP uptake, and supporting PrEP effective use. PEPFAR CI will intensify community-engagement and community-mobilization strategies to accelerate demand creation; strengthen collaboration and referral between PrEP sites, community providers, and other non-PrEP facilities. PrEP sites are identified on the basis of the following criteria: HIV disease burden and growth at the district level, TX CURR and growth at district level, and size and growth of the KP population at both district and site-level. Furthermore, PEPFAR CI will further sensitize facility-based clinicians on PrEP initiation for eligible clients, as civil society has clearly indicated that there is existing demand among their constituents which is not currently being met. PEPFAR CI will also ensure that all clients who initiate on PrEP are asked about experience of violence, provided first-line support, and linked to appropriate violence response services.

PEPFAR CI will also continue advocacy with GF to support MOH to maintain laboratory equipment needed for PrEP initiation workup.

6) **Post-GBV care**

According to the VACS 2020, the PEPFAR CI program faced the following key challenges with respect to post-GBV care: i) gaps in knowledge of the availability of GBV services; ii) In COP 19 and COP 20, GEND_GBV results were low despite high prevalence of violence as reported through the VACS; iv) GBV services and support are lacking as found in the assessment of the Safe and Ethical Index testing standard. To address those major challenges, under the direction of the DREAMS Coordinator, CDI COP21 priorities will focus on:

i. Scaling Parenting for Lifelong Health and SASA to address knowledge gaps and change negative gender norms among parents and community members
ii. Increase the number of GBV Awakening Committees and secure a permanent position for members in facilities
iii. Expand the gender and GBV sessions in the CSE curriculum and consider campaigns such as Every Hour Matters
iv. Providing training and supportive supervision to both providers and IPs on age-appropriate first-line counseling for trauma-informed care
v. Providing immediate access to and provision of the full minimum package of comprehensive and age-appropriate post-violence clinical services
vi. Ensuring no service charges or user fees of any kind, including for clinical services, transportation fees, fees for filling out, filing, or copying forms

7) Systems strengthening support through the MSHP Cooperative Agreement

The cooperative agreement with the MSHP will support the following activities and objectives:

- Monthly and quarterly multi-stakeholder data reviews. These will include the PEPFAR team, implementing partners, MSHP (central and regional/district-level), multilateral stakeholders, and CSO representatives. The focus will be to review site-level data on critical program areas (e.g., case finding among men, VLC/VLS among children and young people, case-finding and continuity of treatment among adult women, etc.) and target interventions to the sites in need of assistance. Performance-based financing will also be included among these interventions, to incentivize high-performing sites.
- Data quality will be maintained and improved through the updating and dissemination of data collection tools aligned with PEFPAR indicators. This would be closely coordinated with HRSA to ensure alignment and complementarity of SOW and avoid duplication. Moreover, the SIGDEP 2 HMIS system will be upgraded to permit interoperability with OPENLIS and other electronic data sources. In future COP years, the PEPFAR team anticipates being able to implement patient-level case-based surveillance systems, for which these SIGDEP upgrades would constitute a first step.
- All technical implementation for laboratory QMS activities will be transferred to the MSHP with PEPFAR support; the national public health laboratory (LNSP) and PEPFAR

team will ensure that this is effective and that the lab activities and results are monitored adequately to provide quality laboratory services to patients. The MSHP will be in charge of the distribution of HIV RT proficiency testing panels, supervision and coaching of laboratory units in addition to performance evaluation of HIV rapid testing services both at clinic and within the community. The DIEM will continue to receive support through the MSHP CoAg to ensure equipment are maintained properly.

Key above site interventions will be supported in the Defense sector to address the main barriers identified by the 2020 MILSID:

- Provide technical support to the Military HIV Sectoral Committee (CSLS) and the Military Strategic Information Department to maintain the electronic medical records (EMR) system, to upgrade DHIS2 version 2.33 to the latest version, with updated SOPs, including comprehensive and quality reporting and data quality improvement (DQI). Revise military health data collection tools as necessary and duplicate for distribution to sites. Efforts will support to make informed decisions to address program gaps related to coverage, continuity in treatment and suppression; and also, to rebuild the HMIS where needed due to losses in health information system human resources as a result of the Ministry of Defense early retirement policy.
- Provide support for optimal Military HRH management through i) the implementation of a Military Human Resources for Health Information System (MHRHIS software); and ii) the development of military HRH policies (including data-driven MHRH recruitment, MHRH carrier development, data-driven MHRH geographic allocation)
- Support specific efforts for resource mobilization: i) develop the 2022-2025 Military HIV Strategic Plan as a tool for resources mobilization; ii) conduct advocacy efforts (workshops/meetings) for the request to increase GoCI and other health sector donors' contribution towards HIV/AIDS for the military sector; iii) provide technical assistance to the Ministry of Defense to effectively track accurate information on expenditures in HIV sector.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

Staffing analysis

The PEPFAR Côte d'Ivoire team is improving its staffing footprint to improve human resources programmatic alignment in order to facilitate and sustain HIV epidemic control, and successfully support the national program. With the implementation of key prevention, care and treatment activities, this will increase the focus of staff time on specific program components such as intensified programmatic management, partner and sub-partner oversight and strategic information analysis. An interagency M&O review of the program will be conducted before COP21 implementation to ensure that the program has the appropriate staffing footprint to meet programmatic goals.

CDC

CDC Côte d'Ivoire and PEPFAR have been providing technical and financial support to the Côte d'Ivoire Ministry of Health and Public Hygiene (MSHP) to establish and continuously improve quality HIV/AIDS services at health facility and community levels, within the framework of the National HIV Strategic Plan (PSN), and in collaboration with the PNLS.

Given the recent shifts in the overall approach to HIV/AIDS control in the country, COP21 guidance provided from S/GAC to ensure 95 percent clinical coverage in PEPFAR-supported sites, and to better align with target setting and PEPFAR programmatic investments in care and treatment management and oversight, CDC Côte d'Ivoire aims to ensure efficient and sustainable implementation of PEPFAR's HIV/AIDS interventions to deliver an AIDS-free generation in a manner that is transparent, accountable, and impactful. To support these efforts, CDC Côte d'Ivoire plans to recruit for a vacant orphans and vulnerable children (OVC) technical advisor position in FY22/COP21. This position will provide technical support to CDC/PEPFAR Côte d'Ivoire in OVC and Dreams program implementation in support of the PEPFAR country program.

CDC Côte d'Ivoire has subsequently realigned their current staffing to provide enhanced partner management over clinical partners implementing activities in high volume sites and identify and implement cost efficiencies throughout the clinical portfolio. When the position mentioned above is filled by the end of FY2022/COP21, CDC Côte d'Ivoire will still be stretching its staffing capacity with the increased demands for site-level monitoring and partner management until IPs' performance improves to assure improved program results and epidemic control.

For the COP21 budget, CDC is approved $605,773 for a Global Health Security Agenda (GHSA) position. This position will function as the GHSA Program Director, allowing the CDC Country Director and Deputy Director to focus solely on PEPFAR.

USAID

USAID continues to provide technical and financial support to the government of Côte d'Ivoire to achieve HIV epidemic control through quality programs and services as well as health system strengthening support.

To ensure optimum use of its PEPFAR staffing footprint, USAID conducted a mapping analysis of existing staff and adjusted assignments to prioritize intensive partner management and sufficient coverage of increased site visits. USAID's staffing assignments enable quality implementation of PEPFAR-funded, USAID programs including successful implementation of community and facility interventions across the HIV continuum, as well as improved collaboration between community and clinical implementing partners (including USAID-supported clinical services tailored for key populations). USAID's Health System Strengthening, Strategic Information, and Community Health teams provide technical and capacity building support to key government entities to reinforce government ownership, oversight, and coordination for sustained epidemic control while working with communities to reach highly

vulnerable populations including OVC, adolescent girls, young women, and key populations at highest risk for HIV acquisition and transmission.

USAID has four vacant PEPFAR positions, all on track to be filled. The Local Capacity Development and Gender Advisor and the Key Population Advisor have been selected, the candidates are undergoing health and security clearances, and are expected to start as soon as clearances are complete. The AGYW Technical Advisor position (a third LES position), will be in solicitation by June 2021. The AGYW Advisor will be based in the USAID office providing oversight and technical guidance to DREAMS implementing partners. This position will also play a key role representing USAID in the interagency space on DREAMS programming. The recruitment process is also underway to fill the Senior Health System Strengthening Technical Advisor and team lead position that was vacated in January 2021.

In COP21 USAID is proposing a HIV Team Lead position (TBD pending interagency staffing assessment) to fill a critical USAID staffing gap. The HIV/AIDS Team Lead will serve as the USAID PEPFAR POC and technical HIV expert overseeing the HIV portfolio, ensuring programs meet PEPFAR and USAID objectives, and respond to GoCI priorities and strategies. S/he will report to the Health Office Director who also oversees USAID's GHSA, PMI, and MCH/FP programs. The HIV/AIDS Team Lead will carry out a full range of consultative, advisory, strategic, coordination, planning and evaluation responsibilities related to the USAID/PEPFAR program. S/he will serve as the day-to-day USAID HIV focal point for interagency collaboration and partnership with other donors and stakeholders. Funding for this position will be determined only after the comprehensive M&O review of the entire program.

DOD

For COP21, DOD has two local positions to cover program performance needs and will continue to use ICASS to limit the number of staff and to optimize administrative and other support cost sharing. DOD has one vacant local hire position, the Strategic Information Specialist. The selected candidate has accepted the offer. After required clearance processes, the new person is expected to start in FY21 Q4. DOD has no new positions proposed for COP21. Reductions have been made to Travel to capitalize on existing virtual platforms.

HRSA

For COP 21, HRSA plans to recruit a direct hire and two local position (LES) to cover program performance and will continue to use its implementing partner and ICASS to limit the number of staff and to optimize administrative and other support cost sharing. HRSA is currently preparing NSDD38 for these positions. Once cleared, we expect the hired staff to effective start work October 1 2021.

PCO

Currently the PCO office currently consists of 3 employees, PEPFAR Country Coordinator, Deputy Coordinator, and the Global Fund Liaison Advisor. Since FY21Q1 the Monitoring & Reporting Coordinator position and the Program Assistant position which was approved during COP20, have been vacant. PCO has been working alongside the US Embassy Abidjan, Human Resource (HR) office to actively recruit for the two positions and expecting to conclude the

recruitment phase for the DREAMS Coordinator position and onboard all 3 employees by FY21Q4.

APPENDIX A -- PRIORITIZATION REQUIRED

Continuous Nature of SNU Prioritization to Reach Epidemic Control
Table A.1

				Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall																							
District	**COP**	**Prioritization**	**Results Reported**	Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
_Military Cote d'Ivoire	**COP 21**	Military	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Abengourou	**COP 15**	Agg	APR16	8%	6%	13%	13%	18%	19%	21%	21%	5%	3%	18%	4%	58%	15%	79%	21%	105%	37%	153%	87%	153%	87%	49%	47%
	COP 16	Agg	APR17	13%	11%	21%	24%	29%	34%	35%	38%	6%	4%	21%	4%	68%	18%	93%	25%	123%	44%	180%	103%	180%	103%	57%	55%
	COP 17	Satur	APR18	26%	37%	26%	37%	26%	37%	26%	37%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%
	COP 18	Satur	APR19	8%	17%	20%	36%	27%	34%	83%	72%	35%	38%	25%	54%	38%	87%	47%	107%	55%	101%	65%	105%	85%	112%	58%	57%
	COP 19	Satur	APR20	72%	77%	51%	140%	53%	53%	67%	59%	33%	68%	60%	94%	105%	150%	98%	139%	100%	127%	81%	99%	60%	94%	44%	73%
	COP 20	Satur	APR21	77%	83%	90%	90%	90%	90%	92%	91%	89%	91%	90%	78%	91%	91%	93%	90%	94%	92%	94%	89%	95%	91%	94%	92%
	COP 21	Satur	APR22	20%	20%	50%	94%	88%	102%	86%	89%	31%	35%	43%	86%	90%	112%	136%	126%	116%	107%	99%	89%	95%	84%	80%	85%
Abobo-Est	**COP 15**	Satur	APR16	14%	14%	23%	30%	32%	43%	38%	48%	7%	3%	26%	4%	84%	15%	116%	21%	153%	37%	223%	89%	223%	89%	71%	47%
	COP 16	Satur	APR17	17%	15%	29%	31%	40%	44%	47%	50%	9%	4%	30%	4%	97%	18%	133%	25%	176%	44%	258%	105%	258%	105%	82%	56%
	COP 17	Satur	APR18	106%	137%	106%	137%	106%	137%	106%	137%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%
	COP 18	Satur	APR19	5%	5%	22%	29%	29%	35%	74%	88%	43%	20%	21%	36%	21%	60%	22%	89%	39%	93%	56%	94%	77%	94%	42%	36%
	COP 19	Satur	APR20	177%	226%	235%	311%	97%	102%	48%	50%	15%	55%	26%	132%	49%	230%	82%	249%	94%	144%	83%	77%	50%	46%	28%	30%
	COP 20	Satur	APR21	79%	81%	95%	95%	95%	95%	95%	95%	88%	91%	89%	78%	90%	91%	91%	89%	92%	91%	93%	89%	93%	91%	92%	91%
	COP 21	Satur	APR22	11%	11%	41%	78%	103%	127%	91%	96%	56%	55%	42%	65%	46%	85%	65%	111%	79%	105%	93%	94%	89%	76%	68%	64%
Abobo-Ouest	**COP 15**	Satur	APR16	20%	18%	33%	38%	46%	56%	55%	62%	8%	4%	28%	5%	92%	21%	126%	28%	166%	50%	244%	119%	244%	119%	78%	64%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 16	Satur	APR17	20%	16%	34%	33%	47%	48%	55%	53%	9%	4%	32%	5%	105%	21%	144%	29%	190%	52%	278%	122%	278%	122%	89%	65%
	COP 17	Satur	APR18	13%	22%	28%	32%	46%	38%	99%	90%	49%	31%	22%	39%	23%	65%	27%	94%	34%	96%	63%	93%	77%	95%	43%	37%
	COP 18	Satur	APR19	136%	168%	136%	168%	136%	168%	136%	168%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%
	COP 19	Satur	APR20	289%	224%	413%	336%	339%	275%	211%	236%	155%	150%	128%	219%	143%	402%	169%	543%	199%	407%	262%	278%	164%	212%	134%	173%
	COP 20	Satur	APR21	83%	82%	96%	96%	96%	96%	96%	96%	89%	92%	90%	79%	91%	92%	93%	91%	94%	92%	94%	90%	94%	92%	94%	92%
	COP 21	Satur	APR22	20%	20%	68%	49%	144%	134%	110%	106%	82%	59%	73%	60%	66%	91%	97%	113%	93%	111%	107%	99%	100%	80%	87%	72%
Adjame-Plateau-Attecoube	COP 15	Agg	APR16	5%	4%	8%	9%	11%	12%	13%	14%	5%	3%	16%	4%	51%	15%	70%	21%	93%	37%	135%	87%	135%	87%	43%	47%
	COP 16	Agg	APR17	6%	5%	10%	10%	15%	15%	17%	17%	5%	4%	19%	4%	62%	18%	84%	24%	111%	43%	163%	101%	163%	101%	52%	54%
	COP 17	Agg	APR18	45%	35%	45%	35%	45%	35%	45%	35%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%
	COP 18	Agg	APR19	13%	5%	16%	16%	21%	27%	30%	41%	15%	17%	14%	33%	20%	67%	35%	99%	34%	102%	78%	102%	86%	91%	49%	41%
	COP 19	Satur	APR20	57%	35%	77%	84%	49%	56%	29%	39%	14%	40%	22%	61%	33%	121%	66%	150%	75%	143%	92%	90%	75%	62%	54%	53%
	COP 20	Satur	APR21	81%	77%	86%	86%	86%	86%	87%	87%	93%	94%	93%	80%	95%	94%	95%	93%	96%	94%	96%	92%	96%	94%	96%	94%
	COP 21	Satur	APR22	20%	20%	57%	51%	91%	107%	46%	66%	24%	21%	40%	43%	41%	69%	49%	95%	56%	95%	71%	87%	67%	61%	56%	60%
Adzope	COP 15	Agg	APR16	6%	4%	10%	8%	13%	11%	16%	12%	2%	1%	6%	1%	19%	6%	26%	8%	34%	13%	50%	32%	50%	32%	16%	17%
	COP 16	Agg	APR17	10%	6%	16%	13%	23%	19%	27%	22%	2%	1%	6%	2%	20%	7%	28%	9%	36%	17%	53%	39%	53%	39%	17%	21%
	COP 17	Agg	APR18	32%	22%	32%	22%	32%	22%	32%	22%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%
	COP 18	Agg	APR19	40%	43%	45%	48%	29%	32%	22%	59%	11%	37%	29%	71%	30%	101%	47%	110%	48%	80%	72%	58%	69%	71%	33%	25%
	COP 19	Satur	APR20	52%	22%	75%	81%	54%	56%	14%	36%	10%	42%	27%	73%	34%	95%	34%	89%	77%	106%	71%	67%	67%	55%	55%	59%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 20	Satur	APR21	80%	86%	94%	94%	93%	94%	95%	95%	91%	92%	91%	79%	92%	93%	93%	91%	94%	93%	95%	91%	95%	93%	95%	93%
	COP 21	Satur	APR22	50%	50%	143%	129%	11%	144%	33%	46%	28%	44%	41%	95%	43%	114%	95%	116%	122%	87%	100%	66%	80%	59%	51%	38%
Agboville	**COP 15**	Agg	APR16	9%	7%	15%	15%	21%	21%	24%	24%	3%	2%	10%	2%	34%	9%	46%	13%	61%	23%	89%	53%	89%	53%	28%	29%
	COP 16	Agg	APR17	12%	8%	19%	17%	27%	25%	32%	28%	3%	2%	11%	2%	35%	9%	48%	12%	63%	22%	93%	52%	93%	52%	30%	28%
	COP 17	Agg	APR18	30%	27%	30%	27%	30%	27%	30%	27%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%
	COP 18	Agg	APR19	89%	162%	42%	57%	31%	35%	35%	43%	19%	25%	34%	75%	37%	115%	44%	110%	71%	109%	67%	66%	62%	60%	34%	26%
	COP 19	Satur	APR20	47%	68%	44%	60%	31%	34%	18%	17%	11%	22%	14%	39%	19%	59%	25%	56%	42%	68%	43%	43%	41%	44%	32%	38%
	COP 20	Satur	APR21	76%	81%	96%	95%	95%	95%	96%	95%	90%	93%	91%	78%	92%	92%	93%	91%	94%	92%	95%	90%	95%	92%	95%	92%
	COP 21	Satur	APR22	33%	33%	91%	122%	72%	74%	34%	52%	21%	64%	34%	93%	50%	121%	91%	119%	108%	88%	95%	66%	80%	46%	47%	38%
Agnibilekrou	**COP 15**	Sust	APR16	11%	9%	18%	18%	26%	26%	30%	29%	5%	3%	18%	4%	60%	17%	82%	23%	109%	40%	159%	95%	159%	95%	51%	51%
	COP 16	Sust	APR17	9%	7%	14%	15%	20%	22%	24%	25%	6%	3%	20%	4%	65%	16%	88%	22%	117%	39%	171%	92%	171%	92%	55%	50%
	COP 17	Sust	APR18	29%	27%	29%	27%	29%	27%	29%	27%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%
	COP 18	Sust	APR19	0%	0%	22%	32%	18%	23%	64%	34%	26%	20%	20%	35%	27%	59%	24%	84%	44%	71%	53%	71%	93%	92%	44%	46%
	COP 19	Satur	APR20	90%	96%	77%	110%	53%	29%	31%	22%	15%	41%	9%	46%	61%	84%	48%	91%	71%	88%	55%	66%	63%	91%	19%	44%
	COP 20	Satur	APR21	78%	83%	90%	90%	90%	89%	89%	90%	88%	92%	90%	78%	91%	92%	92%	90%	94%	92%	94%	90%	94%	91%	94%	92%
	COP 21	Satur	APR22	0%	0%	94%	50%	95%	91%	94%	74%	27%	41%	19%	54%	18%	72%	32%	105%	73%	95%	95%	91%	121%	78%	89%	98%
Akoupe	**COP 15**	Agg	APR16	9%	5%	15%	10%	20%	15%	24%	17%	2%	2%	7%	2%	24%	9%	32%	13%	43%	23%	63%	54%	63%	54%	20%	29%
	COP 16	Agg	APR17	12%	8%	19%	16%	27%	24%	32%	26%	4%	3%	13%	3%	43%	13%	59%	17%	78%	31%	115%	72%	115%	72%	37%	39%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 17	Agg	APR18	33%	17%	33%	17%	33%	17%	33%	17%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%
	COP 18	Agg	APR19	167%	248%	159%	131%	43%	75%	62%	81%	5%	44%	48%	158%	83%	211%	103%	216%	123%	243%	120%	122%	132%	113%	71%	47%
	COP 19	Satur	APR20	107%	111%	117%	87%	42%	61%	29%	33%	7%	39%	13%	77%	29%	82%	45%	93%	67%	147%	67%	67%	88%	97%	46%	57%
	COP 20	Satur	APR21	67%	71%	94%	94%	94%	94%	93%	97%	93%	93%	92%	79%	94%	93%	94%	92%	95%	93%	96%	92%	95%	93%	96%	93%
	COP 21	Satur	APR22	0%	0%	189%	144%	91%	127%	33%	52%	3%	55%	13%	101%	26%	131%	96%	170%	121%	120%	103%	77%	106%	73%	82%	50%
Alepe	COP 15	Sust	APR16	10%	4%	16%	9%	22%	13%	26%	15%	2%	1%	7%	2%	25%	7%	34%	10%	45%	17%	65%	41%	65%	41%	21%	22%
	COP 16	Sust	APR17	13%	6%	22%	13%	31%	19%	37%	21%	2%	2%	7%	2%	23%	10%	32%	14%	42%	24%	62%	57%	62%	57%	20%	31%
	COP 17	Sust	APR18	35%	21%	35%	21%	35%	21%	35%	21%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%
	COP 18	Sust	APR19	162%	177%	57%	125%	35%	23%	28%	61%	6%	24%	23%	73%	50%	113%	61%	121%	74%	97%	81%	106%	96%	125%	50%	47%
	COP 19	Satur	APR20	77%	241%	87%	241%	87%	63%	39%	40%	25%	18%	8%	72%	46%	116%	50%	140%	120%	196%	135%	155%	122%	169%	98%	150%
	COP 20	Satur	APR21	81%	88%	93%	86%	88%	89%	94%	91%	85%	91%	87%	77%	89%	91%	91%	89%	92%	91%	93%	89%	94%	90%	92%	91%
	COP 21	Satur	APR22	0%	0%	100%	175%	91%	118%	47%	53%	4%	27%	50%	87%	66%	73%	86%	116%	119%	90%	78%	93%	103%	73%	58%	74%
Anyama	COP 15	Agg	APR16	6%	4%	11%	8%	15%	12%	17%	13%	3%	1%	10%	2%	33%	7%	45%	10%	60%	18%	87%	42%	87%	42%	28%	22%
	COP 16	Agg	APR17	7%	6%	11%	12%	15%	17%	18%	19%	4%	2%	13%	2%	44%	9%	60%	12%	79%	22%	115%	52%	115%	52%	37%	28%
	COP 17	Agg	APR18	33%	27%	33%	27%	33%	27%	33%	27%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%
	COP 18	Agg	APR19	21%	44%	49%	31%	58%	61%	75%	132%	33%	59%	21%	40%	38%	80%	35%	117%	45%	91%	55%	115%	80%	102%	54%	48%
	COP 19	Satur	APR20	324%	234%	284%	146%	119%	164%	79%	126%	56%	64%	65%	139%	75%	190%	94%	245%	110%	201%	111%	128%	113%	153%	781%	111%
	COP 20	Satur	APR21	86%	89%	95%	94%	93%	94%	95%	96%	90%	93%	92%	80%	93%	93%	94%	92%	95%	93%	96%	91%	96%	93%	95%	93%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 21	Satur	APR22	0%	0%	106%	73%	90%	100%	94%	91%	34%	21%	108%	44%	76%	55%	44%	101%	92%	76%	68%	82%	76%	62%	66%	66%
Arrah	**COP 15**	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	100%	100%	38%	43%	70%	100%	75%	119%	42%	42%	21%	43%	68%	59%	46%	84%	81%	90%	91%	87%	100%	93%	96%	128%
Bangolo	**COP 15**	Agg	APR16	2%	1%	3%	2%	5%	3%	6%	3%	1%	1%	5%	1%	15%	4%	21%	5%	28%	9%	41%	22%	41%	22%	13%	12%
	COP 16	Agg	APR17	2%	1%	3%	3%	4%	4%	4%	4%	2%	1%	6%	1%	21%	6%	29%	8%	38%	14%	56%	32%	56%	32%	18%	17%
	COP 17	Agg	APR18	75%	65%	75%	65%	75%	65%	75%	65%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%
	COP 18	Agg	APR19	0%	0%	8%	6%	3%	11%	10%	59%	4%	7%	4%	34%	17%	50%	19%	53%	26%	41%	42%	41%	38%	33%	15%	21%
	COP 19	Satur	APR20	6%	6%	2%	2%	3%	5%	3%	4%	6%	5%	14%	7%	12%	12%	7%	13%	11%	17%	17%	18%	12%	19%	6%	22%
	COP 20	Satur	APR21	73%	87%	85%	86%	86%	85%	86%	86%	90%	91%	91%	78%	92%	91%	93%	90%	94%	91%	95%	89%	94%	91%	94%	91%
	COP 21	Satur	APR22	0%	0%	47%	21%	41%	100%	34%	51%	11%	24%	16%	84%	43%	73%	61%	80%	98%	63%	89%	49%	72%	34%	45%	48%
Beoumi	**COP 15**	Sust	APR16	4%	3%	7%	7%	9%	10%	11%	11%	2%	1%	7%	2%	22%	7%	30%	9%	40%	16%	58%	38%	58%	38%	19%	20%
	COP 16	Sust	APR17	6%	3%	9%	7%	13%	10%	15%	12%	3%	2%	10%	2%	33%	9%	45%	12%	59%	22%	86%	51%	86%	51%	27%	27%
	COP 17	Sust	APR18	20%	22%	20%	22%	20%	22%	20%	22%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 18	Sust	APR19	61%	85%	61%	85%	61%	85%	61%	85%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%
	COP 19	Satur	APR20	115%	121%	10%	81%	39%	24%	20%	34%	19%	57%	26%	70%	27%	138%	66%	106%	69%	86%	57%	79%	79%	104%	82%	125%
	COP 20	Satur	APR21	77%	78%	91%	91%	88%	89%	89%	88%	93%	93%	92%	79%	94%	93%	94%	91%	95%	93%	96%	91%	96%	93%	95%	93%
	COP 21	Satur	APR22	0%	0%	113%	63%	64%	82%	65%	47%	32%	103%	26%	70%	94%	135%	111%	56%	84%	78%	52%	42%	78%	57%	51%	67%
Bettie	COP 15	Sust	APR16	3%	6%	6%	13%	8%	18%	9%	20%	2%	1%	7%	2%	21%	6%	29%	9%	39%	15%	57%	36%	57%	36%	18%	19%
	COP 16	Sust	APR17	5%	5%	8%	10%	11%	15%	13%	17%	2%	1%	7%	1%	22%	6%	31%	8%	40%	15%	59%	35%	59%	35%	19%	19%
	COP 17	Sust	APR18	10%	20%	10%	20%	10%	20%	10%	20%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%
	COP 18	Sust	APR19	63%	83%	63%	83%	63%	83%	63%	83%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Biankouma	COP 15	Sust	APR16	1%	1%	1%	1%	2%	2%	2%	2%	3%	2%	9%	2%	30%	8%	42%	11%	55%	19%	80%	44%	80%	44%	26%	24%
	COP 16	Sust	APR17	1%	2%	2%	4%	3%	6%	4%	6%	4%	2%	13%	3%	43%	10%	59%	14%	78%	25%	115%	60%	115%	60%	37%	32%
	COP 17	Sust	APR18	11%	11%	11%	11%	11%	11%	11%	11%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%
	COP 18	Sust	APR19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Blolequin	COP 15	Sust	APR16	2%	2%	4%	5%	5%	7%	6%	7%	1%	1%	5%	1%	16%	3%	21%	4%	28%	6%	41%	15%	41%	15%	13%	8%
	COP 16	Sust	APR17	3%	2%	5%	5%	6%	7%	7%	7%	2%	1%	6%	1%	20%	4%	27%	6%	35%	11%	52%	25%	52%	25%	16%	14%
	COP 17	Sust	APR18	9%	11%	9%	11%	9%	11%	9%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%
	COP 18	Sust	APR19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Bocanda	COP 15	Sust	APR16	7%	8%	11%	16%	16%	23%	19%	26%	3%	2%	12%	2%	39%	10%	53%	13%	70%	23%	102%	55%	102%	55%	33%	29%
	COP 16	Sust	APR17	7%	5%	11%	11%	16%	16%	19%	19%	4%	2%	12%	2%	41%	10%	56%	14%	74%	25%	108%	58%	108%	58%	35%	31%
	COP 17	Sust	APR18	12%	14%	12%	14%	12%	14%	12%	14%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%
	COP 18	Sust	APR19	56%	78%	56%	78%	56%	78%	56%	78%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%
	COP 19	Satur	APR20	71%	261%	35%	65%	25%	37%	30%	50%	10%	23%	14%	16%	83%	113%	29%	49%	38%	61%	22%	37%	34%	50%	59%	116%
	COP 20	Satur	APR21	67%	65%	89%	91%	90%	91%	93%	94%	89%	91%	92%	78%	92%	91%	94%	90%	94%	92%	95%	89%	95%	91%	94%	92%
	COP 21	Satur	APR22	0%	0%	22%	50%	92%	100%	53%	84%	25%	14%	18%	27%	84%	93%	62%	54%	60%	53%	43%	38%	46%	49%	63%	80%
Bondoukou	COP 15	Agg	APR16	10%	9%	17%	20%	24%	28%	29%	32%	5%	2%	17%	3%	56%	12%	76%	16%	101%	29%	148%	68%	148%	68%	47%	36%
	COP 16	Agg	APR17	16%	13%	26%	27%	37%	39%	43%	44%	7%	3%	24%	4%	80%	17%	109%	23%	144%	40%	211%	95%	211%	95%	67%	51%
	COP 17	Satur	APR18	93%	104%	93%	104%	93%	104%	93%	104%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%
	COP 18	Satur	APR19	77%	111%	77%	111%	77%	111%	77%	111%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 19	Satur	APR20	10 1%	76 %	94 %	66 %	45 %	56 %	70 %	70 %	50 %	74 %	47 %	10 9%	56 %	13 8%	74 %	16 0%	96 %	15 1%	11 2%	12 6%	10 9%	13 0%	64 %	98 %
	COP 20	Satur	APR21	84 %	76 %	95 %	94 %	94 %	94 %	94 %	95 %	92 %	93 %	92 %	79 %	93 %	93 %	94 %	92 %	95 %	93 %	96 %	91 %	96 %	93 %	96 %	93 %
	COP 21	Satur	APR22	40 %	50 %	10 6%	11 3%	12 6%	12 2%	65 %	97 %	43 %	55 %	53 %	13 3%	12 8%	18 5%	18 1%	17 3%	13 8%	13 7%	13 6%	11 1%	12 1%	98 %	82 %	87 %
Bongouanou	COP 15	Agg	APR16	8%	5%	13 %	11 %	18 %	16 %	22 %	18 %	4%	2%	14 %	2%	45 %	10 %	62 %	14 %	81 %	25 %	11 9%	58 %	11 9%	58 %	38 %	31 %
	COP 16	Agg	APR17	9%	7%	15 %	15 %	21 %	22 %	25 %	25 %	5%	3%	17 %	3%	55 %	14 %	76 %	19 %	10 0%	33 %	14 6%	78 %	14 6%	78 %	47 %	42 %
	COP 17	Agg	APR18	39 %	33 %	39 %	33 %	39 %	33 %	39 %	33 %	86 %	37 %	86 %	37 %	86 %	37 %	86 %	37 %	86 %	37 %	86 %	37 %	86 %	37 %	86 %	37 %
	COP 18	Agg	APR19	78 %	10 8%	78 %	10 8%	78 %	10 8%	78 %	10 8%	84 %	10 0%	84 %	10 0%	84 %	10 0%	84 %	10 0%	84 %	10 0%	84 %	10 0%	84 %	10 0%	84 %	10 0%
	COP 19	Satur	APR20	98 %	68 %	57 %	60 %	51 %	61 %	54 %	56 %	20 %	31 %	11 %	53 %	10 3%	19 3%	40 %	83 %	49 %	77 %	60 %	79 %	67 %	98 %	89 %	18 5%
	COP 20	Satur	APR21	82 %	78 %	92 %	92 %	92 %	91 %	93 %	92 %	89 %	92 %	90 %	78 %	91 %	92 %	93 %	90 %	94 %	92 %	94 %	90 %	94 %	92 %	94 %	92 %
	COP 21	Satur	APR22	50 %	50 %	63 %	40 %	11 5%	16 0%	67 %	76 %	27 %	45 %	25 %	61 %	12 0%	12 4%	85 %	74 %	69 %	74 %	65 %	71 %	93 %	58 %	89 %	10 5%
Botro	COP 15	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	10 0%	10 0%	63 %	15 0%	46 %	67 %	22 %	38 %	43 %	46 %	28 %	58 %	64 %	75 %	81 %	79 %	67 %	70 %	85 %	66 %	77 %	11 4%
Bouafle	COP 15	Satur	APR16	12 %	10 %	20 %	20 %	28 %	29 %	33 %	33 %	4%	2%	14 %	3%	47 %	12 %	64 %	16 %	85 %	28 %	12 4%	67 %	12 4%	67 %	40 %	36 %

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 16	Satur	APR17	15%	13%	25%	28%	35%	40%	42%	45%	6%	4%	22%	4%	72%	17%	98%	24%	12 9%	42%	18 9%	10 0%	18 9%	10 0%	60%	54%
	COP 17	Satur	APR18	16 4%	16 1%	16 4%	16 1%	16 4%	16 1%	16 4%	16 1%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%
	COP 18	Satur	APR19	11 2%	14 4%	11 2%	14 4%	11 2%	14 4%	11 2%	14 4%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%
	COP 19	Satur	APR20	73%	96%	35%	48%	42%	60%	42%	47%	40%	34%	28%	85%	34%	93%	44%	10 3%	58%	10 5%	52%	89%	59%	84%	28%	76%
	COP 20	Satur	APR21	78%	82%	97%	96%	96%	96%	97%	96%	89%	92%	89%	78%	91%	92%	92%	90%	93%	92%	94%	90%	94%	91%	93%	92%
	COP 21	Satur	APR22	25%	25%	87%	83%	70%	11 0%	78%	56%	41%	51%	49%	65%	40%	91%	86%	12 2%	10 1%	10 4%	82%	77%	88%	73%	81%	69%
Bouake-Nord-Est	COP 15	Agg	APR16	6%	4%	10%	8%	14%	11%	17%	13%	4%	2%	12%	2%	40%	8%	54%	11%	72%	20%	10 5%	48%	10 5%	48%	34%	26%
	COP 16	Agg	APR17	7%	6%	12%	12%	16%	18%	20%	20%	5%	2%	15%	3%	51%	11%	70%	15%	92%	27%	13 5%	65%	13 5%	65%	43%	35%
	COP 17	Agg	APR18	43%	28%	43%	28%	43%	28%	43%	28%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%
	COP 18	Agg	APR19	78%	10 8%	78%	10 8%	78%	10 8%	78%	10 8%	84%	10 0%	84%	10 0%	84%	10 0%	84%	10 0%	84%	10 0%	84%	10 0%	84%	10 0%	84%	10 0%
	COP 19	Satur	APR20	49%	10 4%	37%	69%	42%	50%	38%	38%	13%	45%	16%	75%	21%	10 7%	29%	11 2%	58%	84%	59%	58%	56%	52%	37%	58%
	COP 20	Satur	APR21	79%	80%	93%	93%	93%	92%	93%	93%	88%	91%	89%	78%	90%	91%	92%	90%	93%	91%	94%	89%	94%	91%	93%	91%
	COP 21	Satur	APR22	50%	50%	15 3%	93%	11 1%	11 7%	66%	81%	49%	70%	51%	10 6%	71%	10 7%	78%	13 6%	87%	11 0%	92%	73%	97%	58%	68%	58%
Bouake-Nord-Ouest	COP 15	Satur	APR16	21%	20%	35%	42%	49%	61%	58%	68%	7%	4%	24%	5%	78%	21%	10 7%	29%	14 1%	51%	20 7%	12 0%	20 7%	12 0%	66%	64%
	COP 16	Satur	APR17	27%	21%	44%	43%	62%	62%	73%	70%	8%	5%	27%	6%	90%	24%	12 4%	33%	16 3%	59%	23 9%	14 0%	23 9%	14 0%	76%	75%
	COP 17	Satur	APR18	12 1%	16 6%	12 1%	16 6%	12 1%	16 6%	12 1%	16 6%	10 4%	49%	10 4%	49%	10 4%	49%	10 4%	49%	10 4%	49%	10 4%	49%	10 4%	49%	10 4%	49%
	COP 18	Satur	APR19	11 3%	15 6%	11 3%	15 6%	11 3%	15 6%	11 3%	15 6%	12 7%	14 5%	12 7%	14 5%	12 7%	14 5%	12 7%	14 5%	12 7%	14 5%	12 7%	14 5%	12 7%	14 5%	12 7%	14 5%
	COP 19	Satur	APR20	50%	96%	15 6%	16 2%	10 1%	11 7%	13 2%	14 5%	10 0%	82%	41%	98%	46%	15 1%	70%	19 3%	11 9%	15 2%	13 9%	14 6%	12 5%	15 9%	13 7%	19 7%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 20	Satur	APR21	89%	86%	305%	281%	243%	224%	292%	270%	94%	94%	95%	81%	96%	94%	97%	93%	97%	94%	97%	93%	97%	94%	97%	94%
	COP 21	Satur	APR22	20%	20%	147%	158%	193%	200%	127%	155%	98%	81%	84%	92%	70%	121%	84%	172%	139%	149%	124%	127%	133%	109%	102%	108%
Bouake-Sud	COP 15	Satur	APR16	10%	7%	17%	15%	24%	22%	28%	25%	6%	3%	20%	4%	67%	16%	92%	22%	121%	38%	177%	91%	177%	91%	56%	49%
	COP 16	Satur	APR17	13%	8%	22%	18%	31%	25%	36%	29%	7%	4%	25%	4%	82%	18%	112%	25%	148%	44%	217%	104%	217%	104%	69%	56%
	COP 17	Satur	APR18	133%	88%	133%	88%	133%	88%	133%	88%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%
	COP 18	Satur	APR19	83%	115%	83%	115%	83%	115%	83%	115%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%
	COP 19	Satur	APR20	86%	106%	54%	79%	70%	74%	56%	94%	58%	105%	67%	142%	82%	204%	94%	245%	106%	224%	152%	175%	162%	184%	148%	211%
	COP 20	Satur	APR21	78%	79%	90%	91%	90%	90%	91%	91%	93%	94%	94%	80%	95%	94%	96%	93%	96%	94%	96%	92%	97%	94%	96%	94%
	COP 21	Satur	APR22	0%	0%	92%	124%	97%	125%	89%	109%	57%	81%	71%	130%	108%	145%	99%	184%	96%	145%	129%	122%	121%	110%	96%	100%
Bouna	COP 15	Sust	APR16	5%	5%	8%	10%	12%	15%	14%	16%	2%	1%	7%	2%	25%	7%	34%	10%	44%	17%	65%	40%	65%	40%	21%	21%
	COP 16	Sust	APR17	6%	5%	9%	10%	13%	15%	15%	17%	3%	2%	9%	2%	30%	9%	42%	12%	55%	21%	80%	50%	80%	50%	26%	27%
	COP 17	Sust	APR18	14%	17%	14%	17%	14%	17%	14%	17%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%
	COP 18	Sust	APR19	55%	80%	55%	80%	55%	80%	55%	80%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Boundiali	COP 15	Sust	APR16	11%	12%	19%	24%	26%	35%	31%	40%	5%	4%	17%	5%	57%	19%	79%	26%	104%	46%	152%	109%	152%	109%	48%	58%
	COP 16	Sust	APR17	17%	14%	27%	29%	38%	42%	45%	47%	7%	5%	24%	5%	78%	22%	107%	31%	141%	54%	206%	129%	206%	129%	66%	69%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 17	Sust	APR18	25%	26%	25%	26%	25%	26%	25%	26%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%
	COP 18	Sust	APR19	60%	89%	60%	89%	60%	89%	60%	89%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%
	COP 19	Satur	APR20	26%	27%	91%	77%	58%	68%	40%	47%	16%	45%	21%	10 3%	23%	14 0%	71%	13 6%	88%	16 1%	11 4%	13 6%	11 6%	69%	31%	36%
	COP 20	Satur	APR21	77%	80%	92%	92%	93%	93%	94%	95%	89%	92%	91%	78%	91%	91%	93%	90%	94%	91%	94%	89%	95%	91%	94%	91%
	COP 21	Satur	APR22	10 0%	10 0%	80%	16 7%	10 0%	15 8%	95%	80%	23%	66%	19%	13 3%	39%	23 0%	11 7%	19 7%	19 0%	18 1%	17 0%	13 4%	25 3%	68%	95%	46%
Cocody-Bingerville	COP 15	Satur	APR16	34%	26%	56%	55%	78%	79%	92%	89%	8%	5%	27%	5%	89%	22%	12 1%	31%	16 0%	54%	23 4%	12 8%	23 4%	12 8%	75%	69%
	COP 16	Satur	APR17	36%	29%	60%	62%	83%	89%	99%	10 0%	10%	6%	34%	7%	11 2%	28%	15 4%	39%	20 3%	69%	29 7%	16 4%	29 7%	16 4%	95%	88%
	COP 17	Satur	APR18	16 2%	16 2%	16 2%	16 2%	16 2%	16 2%	16 2%	16 2%	11 7%	57%	11 7%	57%	11 7%	57%	11 7%	57%	11 7%	57%	11 7%	57%	11 7%	57%	11 7%	57%
	COP 18	Satur	APR19	10 9%	13 5%	10 9%	13 5%	10 9%	13 5%	10 9%	13 5%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%
	COP 19	Satur	APR20	38 4%	50 4%	34 9%	36 7%	13 0%	97%	57%	53%	35%	74%	48%	17 0%	92%	26 7%	13 1%	27 5%	16 2%	19 1%	12 5%	95%	80%	66%	52%	44%
	COP 20	Satur	APR21	81%	81%	96%	96%	96%	96%	97%	97%	94%	95%	94%	81%	95%	94%	96%	94%	97%	95%	97%	93%	97%	94%	97%	95%
	COP 21	Satur	APR22	25%	25%	53%	87%	11 0%	13 3%	95%	79%	56%	52%	82%	74%	11 5%	10 3%	99%	12 0%	96%	11 8%	83%	10 3%	86%	70%	69%	64%
Dabakala	COP 15	Sust	APR16	7%	5%	12%	11%	17%	16%	21%	18%	2%	1%	7%	1%	22%	5%	30%	7%	40%	12%	59%	29%	59%	29%	19%	16%
	COP 16	Sust	APR17	13%	10%	21%	21%	30%	30%	35%	33%	3%	2%	10%	2%	32%	8%	44%	10%	58%	18%	84%	44%	84%	44%	27%	23%
	COP 17	Sust	APR18	17%	15%	17%	15%	17%	15%	17%	15%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%
	COP 18	Sust	APR19	66%	54%	66%	54%	66%	54%	66%	54%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Dabou	COP 15	Satur	APR16	13%	9%	21%	19%	29%	27%	35%	30%	5%	3%	18%	3%	60%	14%	82%	19%	109%	33%	159%	78%	159%	78%	51%	42%
	COP 16	Satur	APR17	16%	13%	26%	26%	36%	38%	43%	43%	7%	4%	24%	5%	79%	20%	108%	27%	143%	48%	209%	114%	209%	114%	67%	61%
	COP 17	Satur	APR18	109%	97%	109%	97%	109%	97%	109%	97%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%
	COP 18	Satur	APR19	85%	112%	85%	112%	85%	112%	85%	112%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%
	COP 19	Satur	APR20	17%	54%	37%	76%	51%	64%	59%	91%	59%	31%	19%	62%	29%	75%	31%	98%	58%	112%	171%	254%	98%	134%	99%	122%
	COP 20	Satur	APR21	72%	75%	95%	92%	94%	94%	95%	93%	90%	92%	92%	79%	92%	92%	93%	90%	95%	92%	95%	90%	95%	92%	95%	92%
	COP 21	Satur	APR22	0%	0%	35%	43%	63%	97%	88%	104%	35%	43%	26%	40%	43%	53%	31%	61%	62%	79%	75%	72%	82%	75%	85%	92%
Daloa	COP 15	Satur	APR16	12%	7%	19%	14%	27%	21%	32%	24%	6%	4%	21%	5%	68%	19%	93%	25%	123%	45%	180%	107%	180%	107%	58%	57%
	COP 16	Satur	APR17	19%	15%	31%	31%	44%	45%	52%	50%	9%	6%	32%	7%	104%	28%	143%	38%	189%	68%	276%	161%	276%	161%	88%	86%
	COP 17	Satur	APR18	155%	70%	155%	70%	155%	70%	155%	70%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%
	COP 18	Satur	APR19	89%	106%	89%	106%	89%	106%	89%	106%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%
	COP 19	Satur	APR20	60%	82%	60%	42%	41%	80%	35%	54%	25%	65%	35%	104%	57%	138%	77%	137%	87%	142%	73%	100%	79%	98%	29%	77%
	COP 20	Satur	APR21	82%	83%	92%	92%	92%	91%	93%	92%	88%	91%	89%	78%	90%	91%	92%	90%	93%	91%	94%	89%	94%	91%	93%	91%
	COP 21	Satur	APR22	14%	14%	54%	43%	94%	102%	61%	83%	37%	45%	38%	81%	38%	102%	65%	117%	85%	107%	102%	86%	98%	71%	74%	66%
Danane	COP 15	Sust	APR16	3%	3%	5%	7%	6%	10%	8%	12%	4%	2%	12%	2%	41%	10%	56%	13%	74%	24%	108%	56%	108%	56%	35%	30%
	COP 16	Sust	APR17	5%	4%	8%	8%	11%	12%	13%	13%	4%	3%	15%	3%	50%	13%	69%	17%	91%	31%	132%	73%	132%	73%	42%	39%
	COP 17	Sust	APR18	16%	25%	16%	25%	16%	25%	16%	25%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 18	Sust	APR19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%
	COP 19	Satur	APR20	10%	10%	8%	14%	11%	8%	13%	10%	6%	19%	5%	33%	14%	32%	19%	41%	29%	41%	27%	51%	28%	84%	19%	73%
	COP 20	Satur	APR21	76%	86%	87%	88%	87%	87%	88%	89%	88%	91%	89%	78%	91%	91%	92%	90%	93%	91%	94%	89%	94%	91%	93%	92%
	COP 21	Satur	APR22	33%	33%	105%	121%	77%	100%	90%	95%	16%	46%	9%	96%	40%	115%	109%	99%	106%	81%	103%	60%	72%	54%	57%	70%
Daoukro	**COP 15**	Sust	APR16	9%	6%	15%	13%	21%	19%	25%	21%	4%	3%	15%	3%	49%	12%	67%	17%	88%	30%	129%	71%	129%	71%	41%	38%
	COP 16	Sust	APR17	7%	6%	11%	13%	16%	18%	18%	21%	5%	3%	16%	3%	52%	13%	72%	18%	95%	32%	138%	76%	138%	76%	44%	41%
	COP 17	Sust	APR18	33%	22%	33%	22%	33%	22%	33%	22%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%
	COP 18	Sust	APR19	61%	85%	61%	85%	61%	85%	61%	85%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%
	COP 19	Satur	APR20	56%	59%	70%	81%	65%	77%	51%	92%	19%	29%	28%	65%	166%	299%	30%	81%	54%	94%	70%	89%	88%	111%	132%	201%
	COP 20	Satur	APR21	87%	73%	92%	93%	92%	92%	92%	95%	90%	93%	91%	79%	93%	93%	94%	91%	94%	93%	95%	91%	95%	93%	95%	93%
	COP 21	Satur	APR22	50%	50%	57%	107%	111%	100%	72%	47%	23%	43%	5%	49%	48%	87%	46%	56%	46%	54%	73%	49%	74%	55%	77%	81%
Dianra	**COP 15**	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	100%	100%	40%	100%	167%	83%	130%	0%	0%	44%	0%	88%	10%	91%	114%	100%	79%	75%	81%	51%	43%	28%	40%	25%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Didievi	COP 15	Sust	APR16	3%	3%	4%	7%	6%	10%	7%	12%	1%	1%	5%	1%	15%	5%	21%	7%	27%	12%	40%	28%	40%	28%	13%	15%
	COP 16	Sust	APR17	2%	2%	4%	5%	5%	7%	6%	8%	2%	1%	6%	1%	20%	5%	28%	7%	36%	12%	53%	29%	53%	29%	17%	15%
	COP 17	Sust	APR18	13%	20%	13%	20%	13%	20%	13%	20%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%
	COP 18	Sust	APR19	30%	42%	30%	42%	30%	42%	30%	42%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Dikodougou	COP 15	N/A	APR16																						
	COP 16	N/A	APR17																						
	COP 17	N/A	APR18																						
	COP 18	N/A	APR19																						
	COP 19	N/A	APR20																						
	COP 20	N/A	APR21																						
	COP 21	Satur	APR22	0%	0%	140%	60%	57%	57%	64%	0%	27%	44%	32%	74%	45%	130%	83%	175%	110%	99%	89%	79%	100%	74%	51%	62%
Dimbokro	COP 15	Sust	APR16	15%	12%	25%	25%	34%	37%	40%	41%	7%	4%	26%	5%	84%	19%	115%	25%	152%	45%	223%	106%	223%	106%	71%	57%
	COP 16	Sust	APR17	15%	9%	25%	19%	35%	27%	41%	30%	8%	4%	28%	5%	92%	19%	126%	26%	167%	47%	244%	110%	244%	110%	78%	59%
	COP 17	Sust	APR18	46%	40%	46%	40%	46%	40%	46%	40%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%
	COP 18	Sust	APR19	65%	90%	65%	90%	65%	90%	65%	90%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 19	Satur	APR20	40%	42%	79%	31%	76%	75%	76%	100%	31%	41%	30%	74%	46%	137%	37%	12%	81%	154%	88%	155%	93%	170%	136%	310%
	COP 20	Satur	APR21	70%	71%	92%	94%	95%	94%	98%	97%	89%	93%	92%	79%	93%	93%	94%	91%	95%	93%	96%	91%	96%	93%	95%	93%
	COP 21	Satur	APR22	0%	0%	67%	38%	140%	100%	53%	83%	36%	41%	24%	63%	22%	41%	38%	74%	58%	85%	69%	80%	97%	88%	89%	117%
Divo	COP 15	Agg	APR16	8%	8%	13%	17%	18%	24%	21%	27%	3%	2%	12%	3%	39%	11%	53%	14%	70%	26%	102%	60%	102%	60%	33%	32%
	COP 16	Agg	APR17	10%	9%	17%	18%	23%	26%	27%	29%	4%	3%	15%	3%	49%	13%	67%	18%	89%	32%	130%	76%	130%	76%	41%	41%
	COP 17	Agg	APR18	19%	31%	19%	31%	19%	31%	19%	31%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%
	COP 18	Agg	APR19	79%	105%	79%	105%	79%	105%	79%	105%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%
	COP 19	Satur	APR20	67%	80%	52%	52%	29%	33%	22%	21%	16%	23%	7%	42%	23%	64%	28%	76%	42%	80%	61%	66%	58%	53%	45%	45%
	COP 20	Satur	APR21	85%	78%	94%	94%	93%	93%	94%	96%	95%	95%	94%	81%	95%	95%	96%	94%	97%	95%	97%	94%	96%	95%	97%	95%
	COP 21	Satur	APR22	25%	25%	129%	126%	76%	103%	70%	78%	24%	55%	35%	99%	54%	159%	99%	141%	101%	117%	114%	78%	83%	51%	63%	45%
Duekoue	COP 15	Agg	APR16	3%	3%	5%	6%	8%	9%	9%	10%	2%	2%	7%	2%	22%	9%	30%	12%	39%	21%	57%	50%	57%	50%	18%	27%
	COP 16	Agg	APR17	6%	4%	10%	8%	14%	11%	16%	13%	3%	2%	10%	3%	32%	12%	44%	16%	58%	29%	85%	69%	85%	69%	27%	37%
	COP 17	Agg	APR18	26%	34%	26%	34%	26%	34%	26%	34%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%
	COP 18	Agg	APR19	78%	107%	78%	107%	78%	107%	78%	107%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%
	COP 19	Satur	APR20	5%	5%	6%	11%	15%	21%	9%	8%	11%	20%	7%	30%	13%	27%	18%	35%	20%	38%	29%	39%	28%	45%	15%	44%
	COP 20	Satur	APR21	80%	78%	93%	92%	92%	93%	95%	94%	93%	94%	94%	79%	95%	93%	95%	92%	96%	94%	97%	92%	97%	93%	96%	94%
	COP 21	Satur	APR22	25%	25%	48%	100%	69%	95%	63%	62%	26%	78%	24%	117%	20%	113%	93%	117%	83%	87%	103%	71%	93%	51%	61%	54%
Ferkessedougou	COP 15	Sust	APR16	8%	8%	13%	17%	18%	25%	22%	28%	5%	5%	17%	5%	56%	22%	76%	31%	100%	54%	147%	129%	147%	129%	47%	69%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 16	Sust	APR17	13%	9%	21%	19%	29%	28%	34%	31%	6%	5%	22%	6%	72%	26%	98%	35%	130%	62%	189%	147%	189%	147%	61%	79%
	COP 17	Sust	APR18	19%	33%	19%	33%	19%	33%	19%	33%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%
	COP 18	Sust	APR19	60%	89%	60%	89%	60%	89%	60%	89%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%
	COP 19	Satur	APR20	19%	29%	33%	41%	50%	40%	50%	25%	23%	38%	18%	87%	53%	118%	61%	107%	67%	112%	62%	55%	78%	89%	34%	53%
	COP 20	Satur	APR21	88%	91%	89%	88%	89%	90%	91%	92%	88%	92%	90%	78%	92%	90%	92%	90%	93%	91%	94%	89%	94%	91%	94%	91%
	COP 21	Satur	APR22	0%	0%	60%	100%	105%	86%	97%	77%	37%	44%	12%	93%	62%	165%	76%	157%	107%	182%	122%	122%	154%	111%	97%	96%
Fresco	COP 15	Sust	APR16	7%	6%	12%	13%	17%	19%	20%	21%	3%	2%	10%	3%	33%	12%	45%	16%	59%	28%	87%	67%	87%	67%	28%	36%
	COP 16	Sust	APR17	7%	7%	12%	15%	17%	22%	20%	25%	3%	3%	11%	3%	36%	12%	50%	17%	65%	30%	96%	70%	96%	70%	31%	38%
	COP 17	Sust	APR18	16%	12%	16%	12%	16%	12%	16%	12%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%
	COP 18	Sust	APR19	63%	83%	63%	83%	63%	83%	63%	83%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Gagnoa	COP 15	Satur	APR16	13%	9%	21%	19%	30%	28%	35%	31%	5%	3%	16%	4%	52%	14%	71%	20%	94%	35%	138%	83%	138%	83%	44%	44%
	COP 16	Satur	APR17	18%	14%	30%	29%	42%	42%	50%	48%	7%	5%	24%	6%	80%	23%	110%	32%	145%	56%	212%	133%	212%	133%	68%	71%
	COP 17	Satur	APR18	98%	130%	98%	130%	98%	130%	98%	130%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%
	COP 18	Satur	APR19	89%	106%	89%	106%	89%	106%	89%	106%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%
	COP 19	Satur	APR20	43%	28%	34%	36%	37%	37%	25%	24%	15%	29%	18%	59%	35%	75%	40%	90%	50%	88%	49%	68%	55%	69%	26%	57%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 20	Satur	APR21	82%	81%	96%	96%	96%	96%	97%	96%	91%	92%	92%	78%	93%	92%	94%	91%	95%	92%	95%	90%	96%	92%	95%	92%
	COP 21	Satur	APR22	0%	0%	176%	142%	100%	87%	41%	53%	16%	41%	15%	88%	58%	119%	86%	146%	107%	112%	101%	76%	84%	54%	58%	51%
Gagnoa 2	**COP 15**	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	88%	88%	67%	96%	27%	17%	4%	59%	15%	70%	33%	61%	51%	72%	83%	48%	72%	38%	53%	33%	28%	26%
Grand-Lahou	**COP 15**	Sust	APR16	5%	7%	8%	14%	11%	21%	13%	23%	3%	2%	9%	2%	29%	9%	40%	13%	53%	23%	78%	54%	78%	54%	25%	29%
	COP 16	Sust	APR17	9%	8%	15%	17%	21%	24%	24%	27%	4%	3%	13%	3%	41%	12%	57%	17%	75%	30%	110%	71%	110%	71%	35%	38%
	COP 17	Sust	APR18	16%	28%	16%	28%	16%	28%	16%	28%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%
	COP 18	Sust	APR19	57%	76%	57%	76%	57%	76%	57%	76%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%
	COP 19	Satur	APR20	91%	111%	23%	40%	50%	19%	25%	18%	15%	14%	9%	31%	9%	36%	17%	51%	36%	67%	58%	64%	51%	51%	50%	51%
	COP 20	Satur	APR21	69%	77%	89%	91%	90%	91%	94%	93%	88%	92%	89%	77%	90%	91%	92%	90%	93%	92%	94%	89%	94%	91%	93%	91%
	COP 21	Satur	APR22	0%	0%	58%	33%	82%	63%	65%	12%	14%	40%	13%	37%	22%	44%	38%	60%	61%	56%	53%	46%	50%	39%	53%	38%
Gueyo	**COP 15**	Sust	APR16	6%	3%	10%	7%	14%	10%	16%	11%	1%	1%	5%	1%	16%	4%	22%	5%	29%	9%	43%	20%	43%	20%	14%	11%
	COP 16	Sust	APR17	6%	4%	9%	9%	13%	13%	15%	14%	2%	1%	6%	1%	18%	4%	25%	6%	33%	11%	49%	25%	49%	25%	16%	13%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 17	Sust	APR18	5%	5%	5%	5%	5%	5%	5%	5%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%
	COP 18	Sust	APR19	39%	41%	39%	41%	39%	41%	39%	41%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Guiglo	COP 15	Agg	APR16	5%	4%	8%	9%	11%	12%	13%	14%	3%	2%	11%	3%	36%	11%	50%	15%	66%	27%	96%	64%	96%	64%	31%	34%
	COP 16	Agg	APR17	6%	4%	10%	9%	14%	13%	16%	15%	3%	2%	11%	3%	37%	12%	51%	16%	67%	28%	99%	67%	99%	67%	32%	36%
	COP 17	Agg	APR18	35%	29%	35%	29%	35%	29%	35%	29%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%
	COP 18	Agg	APR19	78%	107%	78%	107%	78%	107%	78%	107%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%
	COP 19	Satur	APR20	4%	4%	17%	14%	16%	17%	23%	20%	4%	21%	15%	39%	25%	46%	39%	66%	24%	61%	41%	61%	37%	52%	24%	85%
	COP 20	Satur	APR21	74%	73%	87%	87%	87%	86%	87%	89%	85%	89%	86%	77%	87%	89%	89%	87%	90%	89%	91%	87%	91%	89%	90%	89%
	COP 21	Satur	APR22	50%	50%	36%	71%	74%	84%	79%	86%	12%	57%	23%	113%	64%	113%	116%	137%	112%	130%	83%	78%	95%	58%	58%	66%
Guitry	COP 15	Not Supp	APR16	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 16	Not Supp	APR17	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 17	Not Supp	APR18	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 18	Agg	APR19	79%	105%	79%	105%	79%	105%	79%	105%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Issia	COP 15	Satur	APR16	7%	7%	12%	16%	16%	23%	19%	26%	5%	3%	16%	3%	52%	14%	72%	19%	95%	34%	138%	81%	138%	81%	44%	43%
	COP 16	Satur	APR17	14%	10%	23%	21%	33%	31%	39%	35%	7%	4%	24%	5%	80%	21%	109%	28%	145%	50%	211%	119%	211%	119%	68%	64%
	COP 17	Satur	APR18	95%	123%	95%	123%	95%	123%	95%	123%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%
	COP 18	Satur	APR19	103%	132%	103%	132%	103%	132%	103%	132%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%
	COP 19	Satur	APR20	82%	86%	30%	36%	66%	48%	16%	32%	36%	40%	27%	94%	43%	115%	62%	137%	83%	128%	72%	108%	83%	105%	38%	75%
	COP 20	Satur	APR21	81%	81%	88%	89%	88%	89%	89%	89%	90%	92%	91%	78%	92%	92%	93%	91%	95%	92%	95%	90%	95%	92%	95%	93%
	COP 21	Satur	APR22	33%	33%	91%	70%	106%	77%	58%	69%	18%	57%	17%	99%	36%	117%	85%	149%	119%	128%	113%	84%	104%	79%	89%	70%
Jacqueville	COP 15	Sust	APR16	7%	4%	11%	8%	16%	12%	19%	13%	2%	1%	6%	1%	20%	5%	27%	7%	36%	12%	53%	29%	53%	29%	17%	16%
	COP 16	Sust	APR17	10%	6%	16%	12%	22%	17%	26%	19%	3%	2%	10%	2%	33%	9%	45%	13%	60%	23%	88%	54%	88%	54%	28%	29%
	COP 17	Sust	APR18	20%	11%	20%	11%	20%	11%	20%	11%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%
	COP 18	Sust	APR19	57%	76%	57%	76%	57%	76%	57%	76%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%
	COP 19	Satur	APR20	24%	25%	12%	12%	45%	26%	24%	20%	4%	15%	5%	30%	13%	41%	22%	48%	34%	56%	45%	55%	37%	39%	41%	47%
	COP 20	Satur	APR21	67%	70%	94%	86%	92%	88%	92%	95%	92%	93%	95%	80%	94%	93%	93%	90%	96%	92%	97%	90%	96%	93%	95%	92%
	COP 21	Satur	APR22	0%	0%	20%	20%	57%	86%	50%	64%	18%	25%	5%	37%	23%	38%	44%	69%	30%	50%	56%	40%	31%	43%	42%	50%
Kani	COP 15	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	100%	100%	167%	133%	22%	78%	67%	125%	11%	14%	9%	108%	42%	133%	93%	131%	114%	95%	114%	41%	64%	22%	52%	27%
Katiola	COP 15	Sust	APR16	12%	6%	20%	12%	28%	18%	33%	20%	4%	2%	12%	2%	40%	8%	55%	11%	73%	20%	107%	47%	107%	47%	34%	25%
	COP 16	Sust	APR17	14%	7%	23%	15%	32%	21%	38%	24%	4%	2%	15%	3%	48%	11%	66%	14%	87%	26%	127%	61%	127%	61%	40%	32%
	COP 17	Sust	APR18	21%	17%	21%	17%	21%	17%	21%	17%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%
	COP 18	Sust	APR19	72%	59%	72%	59%	72%	59%	72%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%
	COP 19	Satur	APR20	117%	124%	68%	57%	92%	64%	63%	181%	44%	55%	25%	66%	34%	56%	32%	59%	38%	85%	73%	126%	73%	195%	26%	103%
	COP 20	Satur	APR21	79%	84%	93%	89%	90%	91%	91%	95%	91%	93%	90%	79%	93%	92%	94%	91%	95%	93%	95%	91%	95%	92%	95%	93%
	COP 21	Satur	APR22	0%	0%	50%	64%	127%	153%	100%	117%	34%	93%	49%	95%	74%	117%	89%	116%	117%	111%	122%	103%	145%	122%	91%	112%
Kong	COP 15	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	0%	0%	86%	57%	0%	89%	0%	0%	0%	70%	100%	98%	95%	69%	81%	54%	44%	44%	61%	26%	33%	14%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Korhogo	COP 15	Satur	APR16	13%	10%	21%	22%	30%	32%	35%	35%	6%	4%	22%	4%	73%	18%	100%	24%	132%	43%	192%	103%	192%	103%	61%	55%
	COP 16	Satur	APR17	16%	13%	26%	27%	36%	40%	43%	45%	8%	5%	27%	5%	89%	22%	122%	30%	161%	54%	236%	128%	236%	128%	75%	68%
	COP 17	Satur	APR18	126%	111%	126%	111%	126%	111%	126%	111%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%
	COP 18	Satur	APR19	89%	131%	89%	131%	89%	131%	89%	131%	116%	141%	116%	141%	116%	141%	116%	141%	116%	141%	116%	141%	116%	141%	116%	141%
	COP 19	Satur	APR20	132%	113%	105%	108%	78%	86%	83%	71%	61%	116%	44%	233%	197%	306%	186%	286%	159%	209%	137%	123%	114%	974%	407%	707%
	COP 20	Satur	APR21	82%	82%	94%	94%	94%	94%	96%	95%					94%		95%		95%	92%	96%	90%	96%	92%	95%	
	COP 21	Satur	APR22	29%	33%	129%	175%	115%	122%	104%	79%	44%	73%	23%	102%	94%	181%	148%	198%	130%	162%	129%	119%	115%	105%	867%	877%
Korhogo 2	COP 15	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	67%	133%	25%	75%	29%	0%	20%	17%	0%	77%	64%	87%	94%	61%	30%	60%	36%	13%	23%	18%	31%	14%
Kouassikouassikro	COP 15	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	0%	0%	150%	150%	100%	100%	0%	0%	80%	50%	217%	300%	86%	72%	44%	43%	18%	8%	18%	0%	78%	108%
Kouibly	COP 15	Sust	APR16	2%	1%	3%	2%	5%	3%	5%	4%	2%	1%	6%	1%	19%	5%	26%	7%	34%	12%	50%	28%	50%	28%	16%	15%
	COP 16	Sust	APR17	3%	2%	5%	5%	7%	7%	8%	8%	2%	1%	8%	2%	25%	7%	34%	9%	45%	17%	66%	40%	66%	40%	21%	21%
	COP 17	Sust	APR18	8%	6%	8%	6%	8%	6%	8%	6%	38%	18%	38%	18%	38%	18%	38%	18%	38%	18%	38%	18%	38%	18%	38%	18%
	COP 18	Sust	APR19	35%	48%	35%	48%	35%	48%	35%	48%	81%	94%	81%	94%	81%	94%	81%	94%	81%	94%	81%	94%	81%	94%	81%	94%
	COP 19	Satur	APR20	8%	9%	6%	6%	19%	11%	12%	12%	3%	13%	2%	14%	6%	26%	17%	31%	24%	40%	30%	40%	30%	51%	21%	68%
	COP 20	Satur	APR21	95%	76%	84%	87%	87%	87%	87%	85%	87%	91%	88%	78%	89%	91%	91%	88%	92%	91%	93%	89%	94%	90%	93%	91%
	COP 21	Satur	APR22	0%	0%	55%	55%	93%	120%	64%	23%	0%	46%	5%	62%	19%	71%	67%	72%	70%	63%	82%	50%	60%	48%	62%	52%
Koumassi	COP 21	Satur	APR22	17%	17%	51%	95%	115%	112%	96%	94%	56%	44%	55%	54%	44%	77%	72%	101%	72%	109%	89%	96%	88%	77%	65%	66%
	COP 15	Agg	APR16	11%	7%	18%	15%	25%	22%	29%	24%	5%	3%	18%	3%	60%	12%	82%	17%	109%	30%	159%	71%	159%	71%	51%	38%
	COP 16	Agg	APR17	12%	9%	21%	20%	29%	28%	34%	32%	7%	3%	23%	4%	74%	16%	102%	22%	135%	39%	197%	91%	197%	91%	63%	49%
	COP 17	Agg	APR18	48%	38%	48%	38%	48%	38%	48%	38%	104%	46%	104%	46%	104%	46%	104%	46%	104%	46%	104%	46%	104%	46%	104%	46%
	COP 18	Agg	APR19	82%	101%	82%	101%	82%	101%	82%	101%	77%	82%	77%	82%	77%	82%	77%	82%	77%	82%	77%	82%	77%	82%	77%	82%
	COP 19	Satur	APR20	135%	98%	184%	249%	114%	159%	86%	105%	43%	57%	47%	136%	48%	224%	91%	289%	121%	227%	134%	144%	102%	103%	68%	82%
	COP 20	Satur	APR21	81%	80%	93%	93%	93%	93%	94%	94%	90%	92%	90%	78%	91%	92%	93%	90%	94%	92%	94%	90%	95%	92%	94%	92%
Kounahiri	COP 15	N/A	APR16																								

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	80%	0%	29%	71%	110%	30%	0%	41%	0%	66%	33%	136%	29%	125%	104%	103%	118%	43%	83%	36%	53%	49%
Koun-Fao	**COP 15**	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	27%	36%	120%	129%	43%	87%	32%	46%	17%	60%	17%	75%	58%	91%	69%	92%	95%	107%	102%	94%	71%	102%
Kouto	**COP 15**	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	33%	83%	100%	122%	23%	69%	0%	39%	22%	88%	28%	119%	125%	131%	114%	103%	107%	86%	65%	40%	36%	20%
Lakota	**COP 15**	Sust	APR16	11%	9%	18%	20%	25%	28%	29%	32%	4%	3%	14%	3%	46%	14%	62%	19%	82%	35%	121%	82%	121%	82%	39%	44%
	COP 16	Sust	APR17	14%	11%	24%	22%	33%	32%	39%	36%	5%	4%	17%	5%	57%	18%	78%	25%	103%	45%	150%	106%	150%	106%	48%	57%
	COP 17	Sust	APR18	21%	26%	21%	26%	21%	26%	21%	26%	61%	37%	61%	37%	61%	37%	61%	37%	61%	37%	61%	37%	61%	37%	61%	37%
	COP 18	Sust	APR19	63%	83%	63%	83%	63%	83%	63%	83%	72%	81%	72%	81%	72%	81%	72%	81%	72%	81%	72%	81%	72%	81%	72%	81%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Man	**COP 15**	Satur	APR16	7%	4%	12%	9%	16%	13%	19%	14%	5%	3%	16%	3%	52%	14%	71%	19%	94%	33%	137%	79%	137%	79%	44%	42%
	COP 16	Satur	APR17	9%	6%	15%	13%	21%	18%	25%	21%	6%	4%	21%	5%	70%	20%	97%	27%	127%	48%	187%	115%	187%	115%	60%	62%
	COP 17	Satur	APR18	149%	73%	149%	73%	149%	73%	149%	73%	97%	51%	97%	51%	97%	51%	97%	51%	97%	51%	97%	51%	97%	51%	97%	51%
	COP 18	Satur	APR19	84%	114%	84%	114%	84%	114%	84%	114%	103%	115%	103%	115%	103%	115%	103%	115%	103%	115%	103%	115%	103%	115%	103%	115%
	COP 19	Satur	APR20	6%	5%	9%	14%	12%	18%	16%	12%	9%	17%	7%	31%	15%	30%	21%	41%	28%	46%	33%	47%	31%	58%	18%	70%
	COP 20	Satur	APR21	80%	82%	88%	87%	88%	88%	89%	88%	91%	92%	92%	78%	93%	92%	94%	90%	95%	92%	96%	90%	96%	92%	95%	92%
	COP 21	Satur	APR22	20%	20%	106%	112%	85%	118%	53%	59%	28%	41%	24%	101%	38%	103%	86%	121%	93%	93%	99%	69%	93%	62%	63%	69%
Mankono	**COP 15**	Agg	APR16	6%	6%	11%	13%	15%	19%	17%	21%	2%	1%	7%	2%	24%	7%	33%	10%	44%	17%	64%	40%	64%	40%	20%	22%
	COP 16	Agg	APR17	8%	7%	13%	14%	18%	20%	21%	22%	3%	2%	11%	3%	38%	11%	52%	15%	68%	27%	100%	63%	100%	63%	32%	34%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 17	Agg	APR18	33%	27%	33%	27%	33%	27%	33%	27%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%
	COP 18	Agg	APR19	85%	96%	85%	96%	85%	96%	85%	96%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%
	COP 19	Satur	APR20	8%	12%	20%	24%	14%	18%	23%	16%	7%	25%	7%	61%	41%	75%	45%	106%	58%	99%	54%	68%	67%	64%	29%	47%
	COP 20	Satur	APR21	83%	79%	90%	89%	90%	90%	91%	92%	88%	91%	89%	78%	90%	90%	92%	89%	93%	91%	94%	88%	94%	90%	93%	91%
	COP 21	Satur	APR22	0%	0%	92%	69%	95%	139%	82%	126%	23%	29%	18%	69%	67%	105%	80%	135%	91%	106%	90%	85%	77%	51%	57%	47%
M'bahiakro	**COP 15**	Sust	APR16	4%	0%	7%	0%	10%	0%	12%	0%	2%	1%	6%	1%	20%	6%	28%	8%	37%	14%	54%	34%	54%	34%	17%	18%
	COP 16	Sust	APR17	4%	2%	7%	5%	10%	7%	11%	8%	2%	2%	7%	2%	24%	7%	33%	10%	43%	18%	63%	42%	63%	42%	20%	23%
	COP 17	Sust	APR18	18%	15%	18%	15%	18%	15%	18%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%
	COP 18	Sust	APR19	52%	72%	52%	72%	52%	72%	52%	72%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
M'Batto	**COP 15**	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 21	Satur	APR22	100%	100%	78%	111%	108%	73%	90%	53%	17%	57%	6%	41%	85%	135%	77%	75%	72%	58%	81%	56%	58%	47%	77%	87%
Minignan	**COP 15**	Sust	APR16	1%	1%	2%	3%	2%	4%	3%	5%	1%	1%	3%	1%	11%	3%	16%	4%	21%	7%	30%	18%	30%	18%	10%	9%
	COP 16	Sust	APR17	2%	4%	3%	8%	4%	11%	5%	12%	2%	1%	5%	2%	18%	7%	24%	9%	32%	16%	46%	38%	46%	38%	15%	20%
	COP 17	Sust	APR18	0%	0%	0%	0%	0%	0%	0%	0%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%
	COP 18	Sust	APR19	71%	80%	71%	80%	71%	80%	71%	80%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nassian	**COP 15**	Sust	APR16	0%	3%	0%	7%	0%	10%	0%	11%	3%	2%	9%	2%	28%	7%	39%	10%	51%	18%	75%	42%	75%	42%	24%	23%
	COP 16	Sust	APR17	5%	4%	9%	9%	12%	13%	15%	14%	3%	1%	11%	2%	36%	7%	50%	9%	66%	16%	96%	38%	96%	38%	31%	21%
	COP 17	Sust	APR18	31%	6%	31%	6%	31%	6%	31%	6%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%
	COP 18	Sust	APR19	52%	75%	52%	75%	52%	75%	52%	75%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Niakaramadougou	**COP 15**	Sust	APR16	8%	5%	13%	10%	18%	15%	21%	17%	2%	1%	7%	1%	22%	6%	30%	8%	40%	14%	59%	33%	59%	33%	19%	18%
	COP 16	Sust	APR17	7%	6%	12%	13%	17%	19%	20%	21%	2%	1%	8%	1%	26%	6%	36%	8%	47%	14%	69%	34%	69%	34%	22%	18%
	COP 17	Sust	APR18	32%	25%	32%	25%	32%	25%	32%	25%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 18	Sust	APR19	44%	36%	44%	36%	44%	36%	44%	36%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Odienne	**COP 15**	Sust	APR16	9%	9%	15%	20%	21%	28%	25%	32%	3%	2%	9%	2%	29%	8%	40%	11%	53%	19%	78%	45%	78%	45%	25%	24%
	COP 16	Sust	APR17	13%	10%	21%	22%	29%	31%	35%	35%	4%	2%	13%	3%	44%	11%	60%	15%	79%	26%	115%	61%	115%	61%	37%	33%
	COP 17	Sust	APR18	17%	20%	17%	20%	17%	20%	17%	20%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%
	COP 18	Sust	APR19	47%	53%	47%	53%	47%	53%	47%	53%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Ouangolodougou	**COP 15**	Sust	APR16	5%	9%	9%	19%	12%	27%	15%	30%	3%	3%	12%	3%	39%	13%	54%	18%	71%	32%	104%	75%	104%	75%	33%	40%
	COP 16	Sust	APR17	9%	9%	16%	19%	22%	28%	26%	32%	5%	3%	15%	4%	51%	16%	70%	22%	92%	39%	135%	93%	135%	93%	43%	50%
	COP 17	Sust	APR18	8%	19%	8%	19%	8%	19%	8%	19%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%
	COP 18	Sust	APR19	60%	89%	60%	89%	60%	89%	60%	89%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Oume	COP 15	Agg	APR16	5%	4%	9%	9%	12%	13%	15%	14%	3%	2%	10%	3%	34%	11%	47%	14%	62%	26%	90%	60%	90%	60%	29%	32%
	COP 16	Agg	APR17	8%	7%	13%	14%	17%	21%	21%	23%	4%	3%	15%	3%	51%	13%	70%	18%	92%	32%	134%	76%	134%	76%	43%	41%
	COP 17	Agg	APR18	34%	26%	34%	26%	34%	26%	34%	26%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%
	COP 18	Agg	APR19	80%	104%	80%	104%	80%	104%	80%	104%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%
	COP 19	Satur	APR20	83%	70%	50%	48%	20%	48%	29%	58%	19%	58%	12%	85%	15%	96%	34%	113%	61%	86%	53%	68%	60%	66%	27%	59%
	COP 20	Satur	APR21	81%	75%	92%	92%	92%	92%	93%	93%	90%	91%	90%	78%	92%	91%	93%	90%	94%	91%	94%	89%	94%	91%	94%	92%
	COP 21	Satur	APR22	0%	0%	65%	127%	100%	80%	58%	47%	11%	43%	13%	112%	71%	118%	82%	108%	99%	105%	101%	53%	80%	40%	52%	42%
Port-Bouet-Vridi	COP 15	N/A	APR16																						
	COP 16	N/A	APR17																						
	COP 17	N/A	APR18																						
	COP 18	N/A	APR19																						
	COP 19	N/A	APR20																						
	COP 20	N/A	APR21																						
	COP 21	Satur	APR22	33%	33%	49%	80%	120%	116%	87%	89%	34%	51%	28%	74%	28%	101%	71%	117%	83%	126%	106%	99%	103%	71%	69%	57%
Prikro	COP 15	Sust	APR16	5%	4%	8%	9%	11%	14%	13%	15%	3%	2%	12%	2%	39%	10%	53%	14%	70%	25%	102%	58%	102%	58%	33%	31%
	COP 16	Sust	APR17	6%	8%	11%	17%	15%	25%	18%	28%	4%	2%	15%	3%	49%	11%	67%	15%	88%	26%	128%	62%	128%	62%	41%	33%
	COP 17	Sust	APR18	14%	23%	14%	23%	14%	23%	14%	23%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%
	COP 18	Sust	APR19	52%	72%	52%	72%	52%	72%	52%	72%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Sakassou	COP 15	Sust	APR16	14%	12%	23%	25%	32%	36%	37%	41%	4%	3%	13%	3%	44%	13%	60%	17%	79%	31%	11 6%	72%	11 6%	72%	37%	39%
	COP 16	Sust	APR17	16%	16%	16%	13%	27%	28%	38%	41%	45%	46%	6%	3%	20%	4%	65%	16%	89%	22%	11 7%	38%	17 1%	91%	55%	49%
	COP 17	Sust	APR18	69%	69%	69%	58%	69%	58%	69%	58%	69%	58%	96%	46%	96%	46%	96%	46%	96%	46%	96%	46%	96%	46%	96%	46%
	COP 18	Sust	APR19	52%	52%	52%	11 2%	52%	11 2%	52%	11 2%	52%	11 2%	5%	11%	5%	11%	5%	11%	5%	11%	5%	11%	5%	11%	5%	11%
	COP 19	Satur	APR20	21 7%	11 4%	14 9%	43%	77%	51%	92%	11 3%	59%	53%	33%	76%	20%	12 7%	54%	14 4%	80%	13 4%	10 1%	13 9%	13 5%	15 6%	14 6%	25 8%
	COP 20	Satur	APR21	75%	78%	93%	90%	90%	92%	97%	90%	90%	94%	90%	79%	93%	92%	93%	92%	95%	93%	96%	91%	95%	93%	95%	93%
	COP 21	Satur	APR22	0%	0%	11 4%	14 3%	67%	78%	62%	85%	65%	48%	42%	55%	42%	40%	55%	70%	67%	60%	88%	81%	10 2%	84%	94%	12 2%
Sandegue	COP 15	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	100%	100%	24 0%	12 0%	14 3%	10 0%	50%	70%	47%	50%	0%	65%	45%	68%	77%	87%	12 4%	10 4%	10 8%	73%	10 3%	51%	44%	25%
San-Pedro	COP 15	Satur	APR16	8%	7%	14%	14%	19%	20%	23%	23%	4%	3%	15%	4%	49%	15%	67%	20%	88%	36%	12 9%	85%	12 9%	85%	41%	46%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 16	Satur	APR17	10%	8%	16%	16%	22%	23%	27%	26%	6%	4%	19%	5%	64%	18%	87%	25%	115%	45%	168%	106%	168%	106%	54%	57%
	COP 17	Satur	APR18	28%	28%	28%	29%	28%	29%	28%	29%	28%	29%	66%	38%	66%	38%	66%	38%	66%	38%	66%	38%	66%	38%	66%	38%
	COP 18	Satur	APR19	14%	14%	14%	15%	14%	15%	14%	15%	14%	15%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
	COP 19	Satur	APR20	37%	59%	39%	41%	50%	58%	38%	40%	23%	44%	18%	49%	51%	121%	49%	121%	64%	128%	77%	104%	83%	87%	94%	79%
	COP 20	Satur	APR21	81%	82%	91%	90%	90%	90%	91%	91%	92%	93%	92%	79%	94%	93%	95%	92%	95%	93%	96%	91%	96%	93%	95%	93%
	COP 21	Satur	APR22	25%	25%	57%	83%	100%	73%	71%	97%	29%	41%	17%	73%	44%	88%	62%	116%	85%	103%	102%	88%	95%	66%	74%	50%
Sassandra	COP 15	Agg	APR16	6%	4%	9%	8%	13%	12%	16%	13%	2%	2%	8%	2%	28%	10%	38%	13%	50%	23%	73%	55%	73%	55%	23%	30%
	COP 16	Agg	APR17	7%	6%	12%	12%	17%	17%	20%	19%	3%	2%	12%	3%	39%	11%	54%	15%	71%	26%	104%	62%	104%	62%	33%	33%
	COP 17	Agg	APR18	21%	21%	21%	21%	21%	21%	21%	21%	21%	21%	45%	29%	45%	29%	45%	29%	45%	29%	45%	29%	45%	29%	45%	29%
	COP 18	Agg	APR19	88%	92%	88%	92%	88%	92%	88%	92%	78%	69%	78%	69%	78%	69%	78%	69%	78%	69%	78%	69%	78%	69%	78%	69%
	COP 19	Satur	APR20	62%	66%	94%	76%	41%	74%	42%	41%	17%	58%	20%	59%	36%	90%	54%	115%	89%	121%	104%	104%	103%	98%	97%	111%
	COP 20	Satur	APR21	80%	70%	92%	94%	92%	92%	92%	95%	92%	93%	92%	79%	94%	93%	94%	91%	96%	93%	96%	91%	96%	92%	96%	93%
	COP 21	Satur	APR22	0%	0%	21%	29%	52%	76%	52%	83%	16%	10%	9%	44%	22%	61%	58%	88%	56%	65%	58%	50%	48%	39%	43%	41%
seguela	COP 15	Sust	APR16	3%	4%	4%	8%	6%	11%	7%	12%	2%	1%	8%	2%	26%	7%	36%	10%	47%	18%	69%	42%	69%	42%	22%	22%
	COP 16	Sust	APR17	7%	7%	12%	16%	17%	23%	20%	25%	4%	3%	14%	3%	45%	13%	61%	18%	81%	32%	118%	76%	118%	76%	38%	41%
	COP 17	Sust	APR18	10%	18%	10%	18%	10%	18%	10%	18%	64%	34%	64%	34%	64%	34%	64%	34%	64%	34%	64%	34%	64%	34%	64%	34%
	COP 18	Sust	APR19	62%	69%	62%	69%	62%	69%	62%	69%	72%	69%	72%	69%	72%	69%	72%	69%	72%	69%	72%	69%	72%	69%	72%	69%
	COP 19	Satur	APR20	33%	53%	25%	24%	14%	11%	9%	4%	11%	29%	15%	79%	87%	133%	85%	160%	78%	124%	58%	75%	59%	74%	46%	54%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
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				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 20	Satur	APR21	77%	86%	89%	91%	89%	89%	91%	92%	88%	90%	89%	78%	91%	90%	92%	88%	93%	90%	94%	88%	94%	90%	93%	90%
	COP 21	Satur	APR22	0%	0%	62%	100%	116%	26%	62%	46%	22%	124%	35%	91%	25%	107%	105%	126%	140%	95%	96%	69%	99%	40%	52%	32%
Sikensi	**COP 15**	Sust	APR16	5%	3%	8%	7%	11%	10%	13%	11%	2%	1%	6%	1%	19%	4%	25%	5%	34%	9%	49%	22%	49%	22%	16%	12%
	COP 16	Sust	APR17	9%	7%	14%	14%	20%	21%	24%	23%	3%	2%	10%	2%	34%	8%	46%	11%	61%	20%	89%	47%	89%	47%	28%	25%
	COP 17	Sust	APR18	8%	3%	8%	3%	8%	3%	8%	3%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%
	COP 18	Sust	APR19	57%	76%	57%	76%	57%	76%	57%	76%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%
	COP 19	Satur	APR20	84%	87%	47%	22%	33%	42%	17%	15%	3%	19%	2%	22%	7%	33%	23%	52%	40%	55%	48%	49%	40%	37%	28%	28%
	COP 20	Satur	APR21	81%	87%	92%	92%	94%	91%	92%	98%	89%	91%	90%	78%	92%	92%	94%	89%	95%	92%	95%	90%	96%	91%	94%	91%
	COP 21	Satur	APR22	0%	0%	100%	200%	80%	100%	33%	88%	0%	31%	0%	56%	34%	85%	79%	96%	92%	86%	128%	44%	85%	53%	41%	33%
Sinfra	**COP 15**	Agg	APR16	10%	12%	16%	26%	22%	37%	26%	42%	4%	2%	12%	3%	40%	11%	54%	15%	72%	26%	105%	62%	105%	62%	34%	33%
	COP 16	Agg	APR17	16%	12%	27%	26%	37%	37%	44%	42%	5%	3%	16%	4%	54%	15%	74%	20%	98%	36%	144%	85%	144%	85%	46%	46%
	COP 17	Agg	APR18	50%	61%	50%	61%	50%	61%	50%	61%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%
	COP 18	Agg	APR19	80%	104%	80%	104%	80%	104%	80%	104%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%
	COP 19	Satur	APR20	47%	78%	37%	32%	79%	54%	62%	42%	24%	34%	16%	51%	16%	72%	25%	93%	53%	101%	52%	73%	60%	72%	29%	72%
	COP 20	Satur	APR21	81%	88%	95%	96%	95%	94%	97%	97%	90%	92%	92%	79%	92%	92%	93%	91%	95%	92%	95%	90%	95%	92%	94%	92%
	COP 21	Satur	APR22	133%	133%	55%	76%	93%	48%	91%	69%	17%	36%	16%	54%	36%	90%	58%	96%	71%	89%	91%	76%	93%	61%	79%	66%
Soubre	**COP 15**	Agg	APR16	5%	4%	8%	8%	11%	12%	13%	13%	2%	2%	8%	2%	26%	7%	36%	10%	47%	18%	69%	42%	69%	42%	22%	23%
	COP 16	Agg	APR17	6%	5%	9%	10%	13%	14%	16%	16%	3%	2%	11%	2%	35%	10%	48%	13%	63%	24%	92%	56%	92%	56%	30%	30%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 17	Agg	APR18	29%	31%	29%	31%	29%	31%	29%	31%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%
	COP 18	Agg	APR19	88%	92%	88%	92%	88%	92%	88%	92%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%
	COP 19	Satur	APR20	13%	28%	33%	39%	29%	32%	20%	18%	14%	31%	14%	45%	33%	76%	42%	99%	67%	98%	87%	68%	94%	60%	88%	56%
	COP 20	Satur	APR21	80%	78%	86%	87%	86%	86%	88%	87%	94%	95%	95%	82%	96%	95%	96%	94%	97%	95%	97%	94%	97%	95%	97%	95%
	COP 21	Satur	APR22	17%	17%	44%	60%	109%	70%	89%	56%	18%	34%	14%	47%	13%	67%	44%	88%	63%	72%	78%	52%	64%	40%	56%	41%
Tabou	**COP 15**	Agg	APR16	3%	2%	5%	4%	7%	6%	8%	6%	1%	1%	5%	1%	17%	5%	23%	7%	30%	13%	45%	31%	45%	31%	14%	16%
	COP 16	Agg	APR17	4%	2%	6%	4%	8%	6%	10%	7%	2%	2%	8%	2%	26%	8%	35%	11%	46%	20%	68%	47%	68%	47%	22%	25%
	COP 17	Agg	APR18	33%	24%	33%	24%	33%	24%	33%	24%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%
	COP 18	Agg	APR19	88%	92%	88%	92%	88%	92%	88%	92%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%
	COP 19	Satur	APR20	41%	43%	41%	27%	46%	60%	28%	35%	2%	38%	8%	63%	18%	114%	46%	102%	73%	111%	98%	107%	154%	107%	94%	103%
	COP 20	Satur	APR21	85%	76%	90%	90%	89%	90%	91%	91%	89%	92%	91%	78%	92%	92%	93%	90%	95%	92%	95%	90%	95%	92%	95%	92%
	COP 21	Satur	APR22	0%	0%	21%	38%	40%	65%	47%	76%	19%	22%	12%	60%	25%	69%	44%	80%	67%	70%	71%	51%	79%	44%	52%	48%
Tai	**COP 15**	N/A	APR16																								
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
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				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 21	Satur	APR22	0%	0%	11 7%	50 %	10 0%	63 %	31 %	58 %	11 %	18 %	9%	92 %	25 %	96 %	63 %	12 3%	69 %	63 %	86 %	27 %	87 %	20 %	42 %	40 %
Tanda	COP 15	Agg	APR16	12 %	9%	20 %	19 %	28 %	28 %	33 %	32 %	5%	3%	17 %	3%	55 %	13 %	75 %	18 %	99 %	31 %	14 5%	74 %	14 5%	74 %	46 %	40 %
	COP 16	Agg	APR17	16 %	11 %	26 %	24 %	36 %	34 %	43 %	39 %	6%	3%	20 %	4%	67 %	16 %	92 %	22 %	12 2%	39 %	17 8%	91 %	17 8%	91 %	57 %	49 %
	COP 17	Satur	APR18	16 3%	66 %	16 3%	66 %	16 3%	66 %	16 3%	66 %	93 %	44 %	93 %	44 %	93 %	44 %	93 %	44 %	93 %	44 %	93 %	44 %	93 %	44 %	93 %	44 %
	COP 18	Satur	APR19	77 %	11 1%	77 %	11 1%	77 %	11 1%	77 %	11 1%	12 2%	15 2%	12 2%	15 2%	12 2%	15 2%	12 2%	15 2%	12 2%	15 2%	12 2%	15 2%	12 2%	15 2%	12 2%	15 2%
	COP 19	Satur	APR20	35 %	73 %	58 %	66 %	70 %	73 %	56 %	51 %	43 %	36 %	11 %	68 %	23 %	99 %	49 %	14 7%	98 %	17 4%	12 4%	16 0%	12 8%	16 9%	87 %	16 7%
	COP 20	Satur	APR21	79 %	80 %	91 %	90 %	90 %	90 %	92 %	91 %	90 %	92 %	91 %	79 %	92 %	92 %	94 %	91 %	95 %	92 %	95 %	90 %	95 %	92 %	95 %	92 %
	COP 21	Satur	APR22	0%	0%	10 0%	15 0%	12 3%	15 4%	12 2%	10 0%	32 %	33 %	26 %	92 %	62 %	12 4%	90 %	15 6%	91 %	13 6%	15 0%	14 1%	13 5%	11 2%	12 4%	12 0%
Tengrela	COP 15	Sust	APR16	21 %	2%	36 %	4%	49 %	6%	59 %	7%	5%	3%	19 %	4%	62 %	14 %	84 %	20 %	11 1%	35 %	16 3%	83 %	16 3%	83 %	52 %	45 %
	COP 16	Sust	APR17	27 %	13 %	44 %	27 %	62 %	38 %	73 %	43 %	8%	5%	27 %	5%	88 %	22 %	12 0%	30 %	15 9%	53 %	23 2%	12 6%	23 2%	12 6%	74 %	68 %
	COP 17	Sust	APR18	39 %	8%	39 %	8%	39 %	8%	39 %	8%	66 %	30 %	66 %	30 %	66 %	30 %	66 %	30 %	66 %	30 %	66 %	30 %	66 %	30 %	66 %	30 %
	COP 18	Sust	APR19	55 %	81 %	55 %	81 %	55 %	81 %	55 %	81 %	59 %	75 %	59 %	75 %	59 %	75 %	59 %	75 %	59 %	75 %	59 %	75 %	59 %	75 %	59 %	75 %
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Tiassale	COP 15	Agg	APR16	7%	6%	11 %	12 %	15 %	18 %	18 %	20 %	2%	1%	7%	2%	24 %	6%	32 %	9%	43 %	15 %	62 %	37 %	62 %	37 %	20 %	20 %
	COP 16	Agg	APR17	11 %	8%	18 %	17 %	25 %	24 %	30 %	27 %	3%	2%	12 %	2%	39 %	10 %	54 %	14 %	71 %	25 %	10 4%	58 %	10 4%	58 %	33 %	31 %
	COP 17	Agg	APR18	34 %	38 %	34 %	38 %	34 %	38 %	34 %	38 %	55 %	28 %	55 %	28 %	55 %	28 %	55 %	28 %	55 %	28 %	55 %	28 %	55 %	28 %	55 %	28 %

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
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				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 18	Agg	APR19	79%	105%	79%	105%	79%	105%	79%	105%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%
	COP 19	Satur	APR20	96%	63%	46%	57%	38%	33%	23%	21%	10%	25%	10%	39%	16%	49%	28%	78%	51%	65%	52%	53%	58%	41%	34%	38%
	COP 20	Satur	APR21	77%	91%	95%	92%	92%	93%	92%	93%	90%	92%	90%	78%	91%	91%	92%	89%	93%	91%	94%	89%	95%	91%	94%	91%
	COP 21	Satur	APR22	33%	33%	100%	144%	75%	96%	34%	35%	15%	61%	26%	119%	49%	123%	74%	148%	86%	94%	99%	60%	88%	37%	45%	45%
Tiebissou	COP 15	Sust	APR16	8%	7%	13%	16%	19%	22%	22%	25%	3%	1%	9%	2%	29%	6%	39%	9%	52%	16%	76%	37%	76%	37%	24%	20%
	COP 16	Sust	APR17	7%	7%	12%	14%	17%	21%	20%	23%	3%	2%	10%	2%	34%	8%	47%	11%	62%	19%	91%	45%	91%	45%	29%	24%
	COP 17	Sust	APR18	25%	29%	25%	29%	25%	29%	25%	29%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%
	COP 18	Sust	APR19	61%	85%	61%	85%	61%	85%	61%	85%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%
	COP 19	Satur	APR20	116%	122%	29%	107%	41%	61%	111%	76%	28%	49%	9%	24%	55%	129%	20%	71%	28%	100%	63%	108%	76%	106%	93%	201%
	COP 20	Satur	APR21	77%	79%	95%	98%	96%	96%	98%	99%	86%	91%	91%	78%	91%	90%	92%	89%	93%	91%	94%	88%	94%	90%	93%	91%
	COP 21	Satur	APR22	0%	0%	0%	100%	33%	56%	93%	73%	45%	41%	0%	22%	7%	35%	35%	46%	30%	48%	47%	63%	46%	46%	64%	63%
Touba	COP 15	Sust	APR16	2%	2%	3%	5%	4%	7%	5%	7%	1%	1%	4%	1%	14%	5%	20%	6%	26%	11%	38%	27%	38%	27%	12%	14%
	COP 16	Sust	APR17	4%	3%	6%	6%	8%	9%	10%	10%	2%	1%	7%	2%	22%	7%	30%	9%	40%	16%	58%	38%	58%	38%	18%	20%
	COP 17	Sust	APR18	3%	4%	3%	4%	3%	4%	3%	4%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%
	COP 18	Sust	APR19	43%	48%	43%	48%	43%	48%	43%	48%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
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				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Toulepleu	COP 15	Sust	APR16	5%	1%	9%	2%	12%	2%	14%	3%	1%	1%	3%	1%	11%	4%	15%	5%	20%	9%	29%	20%	29%	20%	9%	11%
	COP 16	Sust	APR17	5%	3%	8%	6%	11%	9%	13%	10%	1%	1%	4%	1%	15%	4%	20%	6%	27%	10%	39%	23%	39%	23%	12%	12%
	COP 17	Sust	APR18	0%	0%	0%	0%	0%	0%	0%	0%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%
	COP 18	Sust	APR19	57%	77%	57%	77%	57%	77%	57%	77%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%
	COP 19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP 21	Not Supp	APR22	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Toumodi	COP 15	Sust	APR16	6%	9%	10%	19%	14%	28%	16%	31%	4%	2%	13%	3%	44%	11%	61%	15%	80%	26%	117%	61%	117%	61%	37%	33%
	COP 16	Sust	APR17	7%	7%	11%	15%	15%	22%	18%	25%	4%	3%	15%	3%	49%	13%	67%	18%	89%	31%	130%	74%	130%	74%	41%	40%
	COP 17	Sust	APR18	22%	28%	22%	28%	22%	28%	22%	28%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%
	COP 18	Sust	APR19	56%	78%	56%	78%	56%	78%	56%	78%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%
	COP 19	Satur	APR20	57%	60%	35%	7%	52%	27%	75%	44%	22%	33%	13%	50%	23%	85%	41%	97%	78%	129%	89%	135%	87%	138%	122%	190%
	COP 20	Satur	APR21	84%	87%	89%	88%	89%	87%	88%	89%	88%	91%	91%	78%	91%	91%	92%	89%	94%	91%	94%	89%	94%	91%	93%	91%
	COP 21	Satur	APR22	0%	0%	54%	33%	125%	44%	93%	59%	37%	55%	18%	58%	76%	96%	71%	77%	70%	97%	81%	76%	85%	71%	96%	98%
Transua	COP 15	N/A	APR16																						
	COP 16	N/A	APR17																						
	COP 17	N/A	APR18																						
	COP 18	N/A	APR19																						

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	12 5%	10 0%	90 %	13 0%	82 %	35 %	12 %	17 %	0%	34 %	15 %	63 %	62 %	11 2%	71 %	12 4%	11 3%	11 3%	10 6%	75 %	89 %	83 %
Treichville-Marcory	COP 15	Satur	APR16	42 %	34 %	70 %	72 %	97 %	10 5%	11 5%	11 7%	20 %	17 %	67 %	20 %	22 1%	84 %	30 3%	11 4%	39 9%	20 3%	58 4%	48 0%	58 4%	48 0%	18 7%	25 8%
	COP 16	Satur	APR17	44 %	34 %	74 %	71 %	10 2%	10 3%	12 1%	11 6%	21 %	18 %	74 %	22 %	24 2%	90 %	33 2%	12 3%	43 8%	21 8%	64 1%	51 5%	64 1%	51 5%	20 5%	27 6%
	COP 17	Satur	APR18	10 3%	10 5%	10 3%	10 5%	10 3%	10 5%	10 3%	10 5%	23 7%	18 0%	23 7%	18 0%	23 7%	18 0%	23 7%	18 0%	23 7%	18 0%	23 7%	18 0%	23 7%	18 0%	23 7%	18 0%
	COP 18	Satur	APR19	11 5%	14 2%	11 5%	14 2%	11 5%	14 2%	11 5%	14 2%	12 5%	12 7%	12 5%	12 7%	12 5%	12 7%	12 5%	12 7%	12 5%	12 7%	12 5%	12 7%	12 5%	12 7%	12 5%	12 7%
	COP 19	Satur	APR20	16 5%	23 9%	24 8%	32 1%	26 6%	38 1%	33 1%	48 6%	22 3%	18 8%	19 6%	13 9%	25 2%	29 6%	28 8%	48 5%	27 0%	48 3%	37 6%	38 5%	39 8%	33 0%	38 3%	31 1%
	COP 20	Satur	APR21	80 %	79 %	90 %	89 %	89 %	89 %	91 %	90 %	95 %	95 %	96 %	82 %	96 %	95 %	97 %	94 %	97 %	95 %	97 %	94 %	97 %	95 %	97 %	95 %
	COP 21	Satur	APR22	8%	8%	38 %	38 %	92 %	86 %	81 %	80 %	38 %	40 %	56 %	36 %	44 %	50 %	54 %	82 %	59 %	12 0%	90 %	14 4%	11 9%	14 4%	12 1%	13 5%
Vavoua	COP 15	Sust	APR16	5%	5%	9%	10 %	13 %	14 %	15 %	16 %	2%	1%	7%	2%	22 %	7%	31 %	10 %	40 %	17 %	59 %	41 %	59 %	41 %	19 %	22 %
	COP 16	Sust	APR17	10 %	9%	17 %	19 %	23 %	27 %	27 %	31 %	4%	3%	13 %	3%	44 %	13 %	61 %	18 %	80 %	32 %	11 7%	76 %	11 7%	76 %	37 %	41 %
	COP 17	Sust	APR18	13 %	15 %	13 %	15 %	13 %	15 %	13 %	15 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29 %
	COP 18	Sust	APR19	58 %	75 %	58 %	75 %	58 %	75 %	58 %	75 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86 %
	COP 19	Satur	APR20	35 %	11 0%	58 %	24 %	52 %	55 %	23 %	24 %	20 %	47 %	22 %	10 9%	48 %	92 %	55 %	13 8%	87 %	11 5%	48 %	57 %	57 %	53 %	22 %	46 %
	COP 20	Satur	APR21	73 %	84 %	90 %	89 %	90 %	89 %	91 %	92 %	87 %	90 %	89 %	77 %	89 %	90 %	91 %	88 %	92 %	90 %	93 %	87 %	93 %	90 %	92 %	90 %
	COP 21	Satur	APR22	33 %	33 %	10 5%	11 0%	11 7%	71 %	52 %	51 %	17 %	36 %	9%	71 %	28 %	94 %	99 %	10 7%	87 %	88 %	88 %	53 %	62 %	37 %	55 %	45 %
Yakasse-Attobrou	COP 15	N/A	APR16																								

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																					
				Treatment Coverage at APR by Age and Sex																					
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 16	N/A	APR17																								
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	0%	0%	175%	100%	67%	100%	33%	0%	14%	65%	18%	70%	37%	114%	110%	100%	86%	71%	100%	40%	71%	25%	38%	29%
Yamoussoukro	COP 15	Agg	APR16	8%	8%	14%	16%	20%	23%	23%	26%	5%	3%	17%	4%	57%	15%	78%	21%	103%	37%	151%	87%	151%	87%	48%	47%
	COP 16	Agg	APR17	10%	9%	17%	18%	24%	26%	29%	29%	6%	3%	22%	4%	71%	17%	97%	23%	129%	41%	188%	96%	188%	96%	60%	52%
	COP 17	Agg	APR18	39%	51%	39%	51%	39%	51%	39%	51%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%
	COP 18	Agg	APR19	78%	108%	78%	108%	78%	108%	78%	108%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%
	COP 19	Satur	APR20	26%	37%	39%	55%	35%	49%	83%	82%	60%	35%	33%	71%	81%	176%	40%	123%	59%	14%	77%	138%	88%	133%	125%	185%
	COP 20	Satur	APR21	78%	81%	87%	88%	87%	86%	89%	89%	90%	92%	91%	78%	93%	92%	94%	91%	95%	92%	95%	90%	96%	92%	95%	92%
	COP 21	Satur	APR22	20%	25%	39%	53%	70%	78%	97%	101%	55%	43%	30%	58%	48%	87%	53%	94%	53%	95%	83%	94%	83%	89%	92%	97%
Yopougon-Est	COP 15	Satur	APR16	6%	6%	10%	12%	14%	17%	16%	19%	5%	3%	17%	4%	58%	16%	79%	21%	104%	38%	152%	90%	152%	90%	49%	48%
	COP 16	Satur	APR17	7%	5%	11%	11%	16%	15%	18%	17%	6%	3%	21%	4%	68%	16%	93%	22%	123%	39%	180%	91%	180%	91%	57%	49%
	COP 17	Satur	APR18	107%	114%	107%	114%	107%	114%	107%	114%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%
	COP 18	Satur	APR19	89%	110%	89%	110%	89%	110%	89%	110%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%
	COP 19	Satur	APR20	78%	74%	119%	103%	44%	57%	39%	34%	34%	36%	27%	91%	47%	135%	72%	190%	83%	159%	79%	95%	67%	68%	41%	53%

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 20	Satur	APR21	80%	80%	94%	94%	94%	93%	95%	95%	92%	94%	93%	80%	94%	94%	95%	93%	96%	94%	96%	93%	96%	94%	96%	94%
	COP 21	Satur	APR22	18%	18%	74%	96%	77%	96%	99%	75%	23%	35%	38%	61%	50%	93%	88%	99%	78%	94%	78%	84%	70%	59%	58%	54%
Yopougon-Ouest-Songon	COP 15	Satur	APR16	28%	22%	46%	47%	64%	68%	76%	76%	10%	5%	34%	6%	11 1%	25%	15 2%	34%	20 1%	60%	29 4%	14 2%	29 4%	14 2%	94%	76%
	COP 16	Satur	APR17	28%	22%	47%	47%	65%	68%	77%	76%	11%	6%	39%	7%	12 7%	28%	17 5%	38%	23 1%	68%	33 7%	16 1%	33 7%	16 1%	10 8%	86%
	COP 17	Satur	APR18	15 8%	14 1%	15 8%	14 1%	15 8%	14 1%	15 8%	14 1%	14 8%	62%	14 8%	62%	14 8%	62%	14 8%	62%	14 8%	62%	14 8%	62%	14 8%	62%	14 8%	62%
	COP 18	Satur	APR19	10 5%	12 9%	10 5%	12 9%	10 5%	12 9%	10 5%	12 9%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%
	COP 19	Satur	APR20	14 0%	16 8%	19 9%	19 2%	14 0%	14 9%	16 1%	18 0%	13 0%	15 1%	78%	15 5%	94%	27 2%	10 4%	26 7%	13 8%	29 1%	24 6%	27 7%	66%	66%	74%	87%
	COP 20	Satur	APR21	78%	80%	87%	86%	86%	86%	87%	87%	87%	90%	88%	77%	89%	89%	90%	88%	92%	90%	92%	87%	92%	89%	92%	90%
	COP 21	Satur	APR22	9%	9%	52%	78%	13 7%	13 3%	10 6%	11 3%	94%	69%	64%	69%	55%	84%	72%	12 1%	72%	12 6%	10 9%	12 0%	10 6%	11 6%	94%	99%
Zouhan Hounien	COP 15	Sust	APR16	3%	3%	5%	6%	8%	9%	9%	10%	2%	2%	8%	2%	28%	8%	38%	11%	50%	20%	73%	47%	73%	47%	23%	25%
	COP 16	Sust	APR17	4%	4%	6%	7%	8%	11%	10%	12%	3%	2%	10%	2%	33%	10%	45%	13%	60%	23%	87%	55%	87%	55%	28%	30%
	COP 17	Sust	APR18	8%	6%	8%	6%	8%	6%	8%	6%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%
	COP 18	Sust	APR19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%
	COP 19	Satur	APR20	5%	5%	3%	9%	7%	7%	9%	5%	9%	12%	4%	19%	8%	24%	12%	26%	11%	22%	17%	30%	18%	37%	12%	34%
	COP 20	Satur	APR21	82%	86%	86%	83%	85%	85%	84%	87%	87%	89%	88%	77%	88%	89%	90%	87%	91%	89%	92%	86%	93%	89%	92%	89%
	COP 21	Satur	APR22	0%	0%	87%	64%	50%	95%	58%	74%	17%	29%	14%	61%	39%	58%	69%	66%	72%	51%	56%	30%	53%	36%	39%	34%
Zoukougbeu	COP 15	N/A	APR16																								
	COP 16	N/A	APR17																								

District	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Band to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	COP 17	N/A	APR18																								
	COP 18	N/A	APR19																								
	COP 19	N/A	APR20																								
	COP 20	N/A	APR21																								
	COP 21	Satur	APR22	100%	100%	113%	0%	27%	91%	89%	100%	19%	6%	0%	77%	82%	110%	123%	128%	90%	108%	130%	67%	95%	58%	63%	65%
Zuenoula	**COP 15**	Sust	APR16	8%	8%	12%	17%	17%	24%	21%	27%	4%	3%	14%	4%	46%	15%	64%	20%	84%	36%	123%	84%	123%	84%	39%	45%
	COP 16	Sust	APR17	18%	16%	30%	34%	42%	50%	50%	56%	6%	4%	22%	5%	72%	22%	99%	30%	131%	53%	191%	125%	191%	125%	61%	67%
	COP 17	Sust	APR18	31%	38%	31%	38%	31%	38%	31%	38%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%
	COP 18	Sust	APR19	58%	75%	58%	75%	58%	75%	58%	75%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%
	COP 19	Satur	APR20	115%	75%	43%	41%	7%	31%	25%	27%	36%	73%	12%	63%	35%	67%	43%	89%	38%	78%	54%	66%	59%	70%	28%	65%
	COP 20	Satur	APR21	77%	84%	90%	88%	87%	88%	88%	89%	85%	89%	87%	77%	89%	89%	89%	88%	91%	89%	91%	87%	92%	89%	91%	89%
	COP21	Satur	APR22	0%	0%	83%	42%	53%	65%	85%	38%	13%	23%	15%	90%	18%	73%	70%	94%	55%	66%	67%	54%	59%	47%	60%	58%

APPENDIX B – Budget Profile and Resource Projections

B.1. COP21 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP21 Budget by Program Area

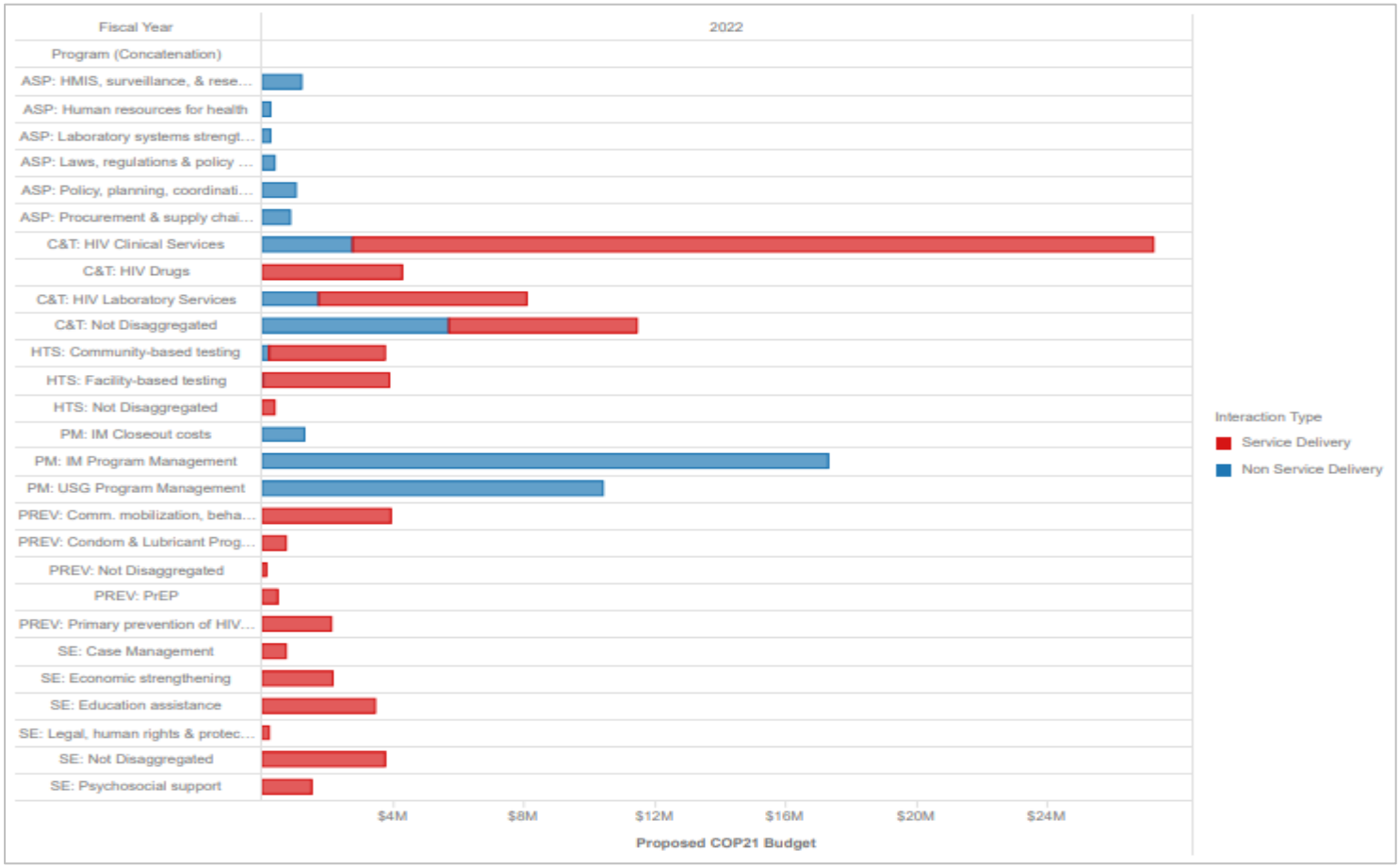

Table B.1.2 COP21 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$4,157,801	**$107,219,687**	**$111,377,488**

Table B.1.3 COP21 Budget by Program and Sub Program Area

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$43,508,966**	**$67,868,522**	**$111,377,488**	**39.06%**	**60.94%**	**100.00%**
C&T	**Total**	**$10,210,319**	**$40,837,448**	**$51,047,767**	**20.00%**	**80.00%**	**100.00%**
	HIV Clinical Services	$2,765,481	$24,452,283	**$27,217,764**	10.16%	89.84%	**100.00%**
	HIV Drugs		$4,281,432	**$4,281,432**		100.00%	**100.00%**
	HIV Laboratory Services	$1,722,155	$6,361,331	**$8,083,486**	21.30%	78.70%	**100.00%**
	Not Disaggregated	$5,722,683	$5,742,402	**$11,465,085**	49.91%	50.09%	**100.00%**
HTS	**Total**	**$213,904**	**$7,856,038**	**$8,069,942**	**2.65%**	**97.35%**	**100.00%**
	Community-based testing	$207,559	$3,572,086	**$3,779,645**	5.49%	94.51%	**100.00%**
	Facility-based testing	$6,345	$3,896,013	**$3,902,358**	0.16%	99.84%	**100.00%**
	Not Disaggregated		$387,939	**$387,939**		100.00%	**100.00%**
PREV	**Total**		**$7,399,509**	**$7,399,509**		**100.00%**	**100.00%**
	Comm. mobilization, behavior & norms change		$3,913,885	**$3,913,885**		100.00%	**100.00%**
	Condom & Lubricant Programming		$750,000	**$750,000**		100.00%	**100.00%**
	Not Disaggregated		$150,170	**$150,170**		100.00%	**100.00%**
	PrEP		$469,561	**$469,561**		100.00%	**100.00%**
	Primary prevention of HIV and sexual violence		$2,115,893	**$2,115,893**		100.00%	**100.00%**
SE	**Total**		**$11,775,527**	**$11,775,527**		**100.00%**	**100.00%**
	Case Management		$713,475	**$713,475**		100.00%	**100.00%**
	Economic strengthening		$2,171,390	**$2,171,390**		100.00%	**100.00%**
	Education assistance		$3,441,955	**$3,441,955**		100.00%	**100.00%**
	Legal, human rights & protection		$197,915	**$197,915**		100.00%	**100.00%**
	Not Disaggregated		$3,758,808	**$3,758,808**		100.00%	**100.00%**
	Psychosocial support		$1,491,984	**$1,491,984**		100.00%	**100.00%**

ASP	**Total**	**$4,092,144**		**$4,092,144**	**100.00%**		**100.00%**
	HMIS, surveillance, & research	$1,213,961		**$1,213,961**	100.00%		**100.00%**
	Human resources for health	$260,479		**$260,479**	100.00%		**100.00%**
	Laboratory systems strengthening	$272,820		**$272,820**	100.00%		**100.00%**
	Laws, regulations & policy environment	$405,000		**$405,000**	100.00%		**100.00%**
	Policy, planning, coordination & management of disease control programs	$1,054,884		**$1,054,884**	100.00%		**100.00%**
	Procurement & supply chain management	$885,000		**$885,000**	100.00%		**100.00%**
PM	**Total**	**$28,992,599**		**$28,992,599**	**100.00%**		**100.00%**
	IM Closeout costs	$1,285,529		**$1,285,529**	100.00%		**100.00%**
	IM Program Management	$17,280,359		**$17,280,359**	100.00%		**100.00%**
	USG Program Management	$10,426,711		**$10,426,711**	100.00%		**100.00%**

Table B.1.4 COP21 Resource Allocation by Program Area and Beneficiary

Fiscal Year	2022													
Program	C&T		HTS		PREV		SE		ASP		PM		Total	
Beneficiary	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total
Total	**$51,047,767**	**100%**	**$8,069,942**	**100%**	**$7,399,509**	**100%**	**$11,775,527**	**100%**	**$4,092,144**	**100%**	**$28,992,599**	**100%**	**$111,377,488**	**100%**
Females	$316,950	1%	$100,038	1%	$4,258,928	58%	$7,434,275	63%	$775,000	19%	$400,000	1%	$13,285,191	12%
Key Pops	$2,375,436	5%	$1,292,289	16%	$697,185	9%			$180,000	4%			$4,544,910	4%
Non-Targeted Pop	$43,633,945	85%	$4,832,410	60%	$1,930,800	26%			$2,996,456	73%	$28,592,599	99%	$81,986,210	74%
OVC	$2,478,556	5%	$549,792	7%	$432,514	6%	$4,341,252	37%					$7,802,114	7%
Pregnant & Breastfeeding Women	$536,314	1%	$1,015,033	13%									$1,551,347	1%
Priority Pops	$1,706,566	3%	$280,380	3%	$80,082	1%			$140,688	3%			$2,207,716	2%

B.2 Resource Projections

For COP21 resource projections, PEPFAR-CI used an incremental budget methodology using COP19 expenditures as a basis for continuing IMs.

Prior to allocating COP21 resources, PEPFAR-CI conducted multiple in-depth reviews of the country program's performance by geography and by population, as of FY2021 Q1. In addition, the USG team conducted a district level review to understand the gaps in coverage by age and sex for case finding, care and treatment, viral load coverage and suppression. Based on the findings, the USG team engaged in robust dialogue with key stakeholders, including MSHP, PNLS, UN System Agencies, and CSOs to identify key programmatic gaps and agree on technical priorities to address these gaps and support the country program.

In an effort to invest COP21 funding in the most efficient way and to ensure that these investments would lead toward epidemic control, the USG team will maintain the site-level prioritization based on PLHIV on ART volume and critical gaps in pediatric viral load based in the 79 districts (previously 60 districts in COP20, with some districts splitting into two). As was done in COP20, in COP21 ART sites will remain classified into three types, with varying degrees of PEPFAR support and investments (see Section 3.0). PEPFAR-funded community-based support will be concentrated in the communes around the 449 sites that make up high impact and moderate impact sites.

PEPFAR-CI conducted a high-level budget review of achievements in comparison to spend at OU level, broken down by program area, and then budget execution by IM versus target achievement. After completing the data review, the PLL was reviewed taking into consideration the earmark allocations for care and treatment and OVC, and how the proposed interventions for COP21 would meet these mandatory budget amounts. In addition, for each intervention, PEPFAR-CI worked with their partners to estimate a cost for the package of services by beneficiary type based on strategies developed by the technical working groups, building budgets for each program area, and remaining abreast to the overall COP21 strategy and budget envelopes. Each package of services considered HRH needs based on rigorous site level HRH analyses, review of further program efficiencies, and synergies between facility and community-based activities. For HTS, PEPFAR-CI worked with IPs to estimate COP19 expenditures by HTS modality, in which outliers were removed from the analyses and certain facility HTS modalities with shared HRH were combined. Program efficiencies were considered to ensure that the HTS COP21 budget aligned with the overall reduced PEPFAR-CI budget envelope.

Final COP21 budget adjustments were made at the IM level, based on programmatic shifts from case finding to continuity of treatment, prioritizing populations with additional resource needs (e.g., MSM, FSW, C/ALHIV, unstable patients), and rebuilding program costs with a focus on site-level service delivery interventions. Budget decisions were made by first allocating for M&O, closing costs, commodities, DREAMS, OVC, KP programming, and above-site activities. DREAMS and OVC funding allocation first removed country-wide activities and the remaining funding was split by IM-based on DREAMS targets. OVC funding allocation for OVC IMs was based on <18 OVC_SERV targets. Some DREAMS funding was allocated to clinical IPs within the four DREAMS districts, but only funding for OVC activities in the community were included. For all IMs, “Program Management” costs were reviewed and reduced as appropriate to ensure maximal support of direct service delivery programming.

Commodities were estimated to account for patients to be tested and expected to be put on ART with respect to the on-going TLD transition and push towards 6-MMD for all adult PLHIV. As for above-site level interventions, they were identified to address key policy barriers and funded accordingly.

APPENDIX C– Minimum Program Requirements

Thanks to PEPFAR advocacy, Côte d'Ivoire has made some progress in meeting the minimum program requirements, but significant work remains to meet COP21 MPRs.

Care and Treatment

1. **Test and Start:** Côte d'Ivoire adopted the Test and Start policy along with Differentiated Service Delivery Models (DSDM) for stable patients in February 2017. Currently, Test and Start is implemented in all PEPFAR-supported sites across all age, sex, and risk groups. DSDM is adopted and being implemented. Continue implementation at 100% of supported sites across all age, sex, and risk groups in 516 sites, 79districts. Ensure >95 linkage across all age, sex, and risk groups in 516 sites, 79 districts. In FY20, linkage to ART was sub-optimum <95%). In response to this issue, USG and MOH conducted several data calls and rapid data quality checks prioritizing districts with the largest gaps. Findings show data integrity challenges, especially for positive identified in the community and reported linked to facilities and referral of patients tested positive in community in sites not supported by PEPFAR. Those challenges are documented and implementing partners are taking the necessary actions to fix them.

2. **Rapid ART Optimization:** The MSHP adopted the transition to TLD in February 2019 with 2-phased implementation approach. The policy was emphasized by a circular note on April 19, 2019, providing additional guidance for the implementation. The initial phase targeting adults and children (>35 kg or 10+ years old) newly initiated on ART started in April 2019 with training of providers at more than 100 high volume ART sites along with dispensation of the drug. The second phase targeted patients already on treatment and women without childbearing potential begun in July 2019 and was scaled up in December 2019 and January 2020 when the MSHP conducted a series of trainings/coaching of providers at 139 prioritized sites. Nevirapine-based regimen has been phased out in treatment protocols. The policy was revised on Feb 14, 2020, to allow transitioning of all adults and adolescents, and women with childbearing potential on TLD by removing the requirements of double contraception, and folic acid for women with childbearing potential. However, those women should be offered comprehensive counseling on the benefits and risks of TLD for informed consent. Despite these challenges, significant progress was made in TLD transition. TLD coverage among patients receiving ART increased from 17% (FY20Q1) to 61% (FY21Q2) with 81% coverage among males 15+. In CP20, MOH revised pediatric treatment guidelines adopting DTG for children <20 kg. During COP20 leading to COP21, PEPFAR CI will work with MSHP and implementing partners to increase uptake of TLD among all PLHIV, with emphasis on women of childbearing age and children.

3. **6MMD:** On February 2019, the MSHP adopted 6 multi-month scripting for stable patients on ART and this policy is currently being scale-up at all sites. Community ART distribution adopted Feb 14, 2020. In October 2020, MOH issued a policy recommending 6MMD as part of a contingency plan to mitigate the impact of COVID-19 on HIV services. USG and implementing partners are making progress in scaling 6MMD. As of March 2021, 34% (82,322/**238,157**) patients on treatment received 6MMD at 516 sites. Consequently, the trends of <3MMD and 3-5MMD are decreasing over time. PEPFAR will support MSHP to implement a phased scale community ARV distribution which started in 10 districts in COP19. In COP21, PEPFAR will continue to expand the implementation of 6 MMD in 100% of ART-supported sites for adults and children 5-14 years with a goal to reach at least 75% of patients on 6MMD in alignment of the contingency plan and the current guidelines, and expand community ARV distribution model to all supported districts.

4. **TPT:** The MSHP adopted Tuberculosis Preventive Therapy (TPT) as part of the routine HIV care package in October 2018 with a phased scale-up approach. The policy initially targeted patients newly enrolled on ART. TPT uptake is very limited though services are offered to patients at no fee. In FY21-Q2, 1,680/1964 ART patients completed TPT, representing 86% completion rate but far below of the target of 72,271. The scale up of TPT has until recently faced significant policy and implementation challenges. For example, national TPT guidelines adopted in October 2018 recommended TPT only for newly enrolled ART patients. The TPT national algorithm at the time required a chest x-ray for patients screening negative for TB, patients who had CD4 counts below 200/mm3 were not eligible for TPT. To overcome the aforementioned policy barriers, PEPFAR Cote d'Ivoire along with Global Fund, WHO and other stakeholders successfully advocated for major changes with the MSHP during FY20 and at the start of FY21. Key changes include: 1) The authorization of TPT for all PLHIV (new and already on treatment); 2) Updating the national TB screening algorithm for PLHIV to eliminate chest x-rays as a requirement; include only the four WHO-approved clinical screening questions; and recommending GeneXpert as the first line diagnostic option for TB in PLHIV; 3) Authorization for the expansion of TPT to an additional 578 sites (including all PEPFAR-supported sites) in FY2021; 4)Updating TPT national guidance, training manuals and data collection tools to account for PEPFAR's recommendations on TB screening questionnaire; 5)Approval for a pilot rollout of TPT using 3HP. Taken together, all these policy breakthroughs are expected to lead to an even more significant leap in the coverage for this indicator in the second half of FY21 and into FY22.

5. **Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections**: In 2018 the MSHP adopted a National VL/EID scale-up plan which is being implemented. National VL/EID optimization exercise was completed in January 2020. Thanks to PEPFAR, Côte d'Ivoire supports a network of 17 VL/EID laboratory with capacity of 525,467 tests/year. All PEPFAR-supported 79 districts have access to VL/EID services. As of FY21-Q2, viral load coverage was 86% and viral load suppression (89%) with 20% of VL sample

collected on DBS samples for rural sites. In COP21, with support from ARPA and in collaboration with the Global Fund, PEPFAR CI will complete the Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ensure ongoing monitoring to reduce morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 2 weeks. The activities will follow the classic four-step framework: 1) Stakeholder Alignment (Define objectives LNO aims to achieve, and process for key stakeholders to work together on helping reach those; 2) Data collection and national level network requirements (Plan and collect site level data and map the network requirements at the national level; 3) Network optimization (Run alternative scenarios that optimize device placement and referral linkages; and 4)Operational plan design (Map enabling interventions, systems and processes that need to be put in place to operationalize the new improved lab network)

Case Finding

6. **Index Testing:** In COP20 safe and ethical index testing is being implemented at all PEPFAR-supported districts and 516 clinical sites for all age, sex, and risk population. Self-testing is occurring for high-risk clients or to partners as part of index testing services. During COP21, PEPFAR CI will ensure that safe and ethical index testing is continued to be implemented with fidelity at all supported sites for different populations, focusing on patients newly initiated on ART, those with unsuppressed viral load, and those currently on ART who have not yet received index testing services. PEPFAR will ensure that consent procedures and confidentiality are protected by adhering to safe and ethical standards, and assessment of intimate partner violence is promoted and established with referral to gender-based violence (GBV) services. All children under 19 years old with an HIV-positive biological parent will be targeted for index testing. In COP21, PEPFAR will ensure all index testing counselors are trained according to Safe and Ethical Index Testing Guidance to make appropriate referrals and assessment. In COP21, PEPFAR will also ensure that all sites are staffed appropriately, and performance reviews are done at site and district levels. In COP21, providers will double efforts in tracking the distribution, use, and reactive results of self-testing through telephone calls and home visits when feasible.

Prevention and OVC

7. **PrEP:** In 2018 the MSHP adopted guidelines for PrEP implementation. Provider training was launched in the second half of 2019 and continued into 2020. Current policy allows PrEP for KPs, HIV-negative people in sero-discordant couples and vulnerable AGYW. IPs are working to scaling-up PrEP to reach COP20 targets of 7,264 for PrEP_NEW, and 9,744 for PrEP_CURR. There has been no stock out issues and there is enough ARV stock (TDF+3TC) to support the implementation. Progress to expand PrEP for the above populations has been slow due to barriers in creatinine and hepatitis B testing currently required before a client can start PrEP. PEPFAR will work with MSHP to

address these barriers to allow same day PrEP initiation per WHO guidelines. Additionally, PEPFAR will work with MSHP to expand community access to PrEP, to better meet clients where they are and reduce the number of clients needing to attend clinics, especially in the context of the COVID-19 pandemic. We will also work to extend the comprehensive prevention service package for HIV-negative clients including PrEP for populations at elevated risk of HIV acquisition including and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices.

8. **OVC:** COP20 OVC interventions align with highest burden areas. PEPFAR is aligning OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9–14-year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management. COP21 PEPFAR will particularly focus on 1) the most at risk children and adolescents such as C/ALHIV, CFSW, Adolescents girls, HIV-exposed children, Breastfeeding, or pregnant Adolescents/women, 2) actively improving index testing for all biological children and siblings (<19 years with unknown HIV status) of HIV+ mothers 3) actively facilitating testing for all children at risk of HIV infection, 4) facilitating systematic linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 5) avoiding and /or reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. PEPFAR will continue to increase the ratio OVC: care givers to 4:1.

Policy & Public Health Systems Support

9. **Elimination of all formal and informal user fees in the public sector:** The MSHP has taken a firm stand on eliminating user fees. In March 2019, the MSHP issued a circular note removing all formal and informal user fees for HIV patients, pregnant women attending facilities, and children under 5 years old. This policy was reinstated in the new circular issued on Feb 14, 2020PEPFAR-CI. MSHP, PEPFAR and Civil CSO are monitoring the implementation during site visits. Overall, there have been fewer reports of user fees. In FY20, PEPFAR staff doing SIMS/GSM site visits have reported a few cases of user fees at a couple of sites. These findings are corroborated by that of the community-led monitoring observatory which reported that 9% (91/1040) patients paid user fees at 12 sites, 85% of which are health booklets and 15% commodities. Those reports have been shared with MSHP for corrective action. In response, the MSHP Office of Inspector General visited sites to monitor and enforce the implementation of the policy. Since then, no further cases of user fees were reported. In COP21, PEPFAR will continue monitoring through ongoing site visits (SIMS/GSM/ others), collaborate with CSOs through the observatory and report to MSHP, and support MSHP to enforce the implementation of the policy. PEPFAR will advocate for free Cervical Cancer screening and treatment of pre-cancerous lesion for HIV-infected women supported by MSHP and Donors.

10. **Continuous Quality Improvement (CQI):** PEPFAR team is working with the MSHP for the adoption of a national CQI policy to provide technical assistance to implement a people-centered, quality improvement (QI) approach, based on a hub-and-spoke model in high-burden districts, to the improvement of linkage, early care engagement among newly diagnosed PLHIV and re-engagement of people with HIV in care in Côte d'Ivoire. As a patient-centered approach, the program seeks to apply standard quality improvement methods of root cause analysis, focus on systems, continuous measurement of key indicators and testing of interventions to improve engagement in care, and ultimately, viral load suppression. Moreover, to inform development of interventions, PEPFAR interventions will foster the active gathering and synthesis of the perspectives of PLHIV, healthcare workers (HCWs) at VCT and ART sites, and policymakers on barriers and enablers of successful linkage, engagement, and continuity of treatment. In collaboration with the PNLS, the Quality Department of the Ministry of Health, and CSOs, including community monitoring partners, the proposed activities seek to achieve these objectives through pursuit of the following six specific aims:

    Develop district-level improvement networks that include HIV testing sites and treatment facilities to strengthen linkage and referral processes to HIV care and treatment.

    - Determine the magnitude of the problem based on existing data, buttressed by continuous measurement at district and facility levels.
    - Convene HCWs, PLWH, and CSOs to map networks of referral between VCT and ART sites and identify referral points with low rates of care linkage and early care engagement according to indicators in (1).
    - Apply "patient journey" methodology, root cause analysis, and other QI methods to identify barriers and enablers of successful linkage and early care engagement among PLWH.
    - Develop performance indicators (process measures) that commonly define linkage to care and early care engagement.
    - Test interventions using QI methods and identify effective interventions through continuous monitoring of indicators developed in (1) and standard MER indicators.

11. **Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils:** PEPFAR is working with MSHP leadership to develop and disseminate new HIV messaging considering the latest evidence on prevention, treatment, and care for the general population, including the concept U=U. In COP21, PEPFAR will continue to provide TA to the MSHP for development of a strategic marketing approach to reposition living with HIV as a management condition (thereby addressing other Key System Barrier of Stigma), treatment literacy and demand creation for HIV services.

12. **Evidence of agency progress toward local, indigenous partner direct funding:** Country ownership of the response is the vision of the GoCI. In FY2019 26% of PEPFAR budget was allocated to local indigenous organizations. This percentage allocation has increased every year. For CDC, in COP 21, of the mechanisms identified to be funded, international organizations are only receiving 46% of the funding. For USAID, in COP21 the proportion of funding to local partners increased to 18% compared to 12% in COP20. Of particular note, in Q4 of FY 22, two new local partners will be introduced to implement USAID's OVC portfolio in non-DREAMS districts. Each agency continues to work with its headquarters to reach the global program requirement and monitor the benchmark.

13. **Evidence of host government assuming greater responsibility of the HIV response:** The GoCI has increased its contribution to the response to HIV over the past years. Its contribution to the purchase of HIV commodities increased to 54% of total needs: $11.3M in CY2018 to $17.5 M in CY2019. GoCI planned investments for commodities during COP19/CY20 implementation period is $19.68M. This represents 11% decrease from prior year investments ($22.3M committed in COP18). The health sector was allocated only 6% of the 2019 budget. In COP21, PEPFAR CI will continue to engage the government to invest more and assume greater responsibility in HIV response and prevention working towards long term program sustainability.

14. **Monitoring and reporting of morbidity and mortality:** Monitoring of morbidity and mortality among patients receiving care and treatment services is critical in the context of low continuity of treatment. Since FY2019, PEPFAR is implementing the mortality and morbidity (TX_ML) required indicator at all supported sites and across all populations. Data will continue to be analyzed on a quarterly basis to inform the program. In COP19, PEPFAR has begun the implementation of LAM assay to diagnose co-morbidities for patients with advanced disease at 2 reference sites. COP20 will extend the LAM and CrAg assay and improve reporting on TX_ML as part of the implementation of an advanced disease package at 30 prioritized sites. In COP21, PEPFAR will scale up implementation of advanced HIV disease package (AHD) at 30 new sites totaling 60 AHD sites.

15. **Scale-up of case-based surveillance and unique identifiers for patients across all sites:** The MSHP approved the concept of implementing a unique patient identifier using securely encrypted biometric code in late COP18 and created a technical working group, which developed the concept note and the tools/software and systems. Currently there is a small-scale implementation at 10 sites in Abidjan. COP20 will not support the development of a master patient index (MPI; client register), which is a required component to implement deduplication of patients across programs and sites. In COP21 the goal of the proposal UPID activities under ARPA would be to ensure UPID solution is integrated with latest EMR (SIGDEP 3.0) and available at all 172 high impact sites, representing approximately 70% of TX CURR supported by PEPFAR and to start development of a Point of Testing UPID module and the Patient Identity Management system to be ready for deployment in COP22.

APPENDIX D– Approved American Rescue Package Act 2021

These COP21 ARPA funds are being provided to PEPFAR Côte d'Ivoire specifically to address the intersection of HIV and COVID to Prevent, prepare for, and respond to coronavirus (including prevention of COVID-19 infection, illness, and death among PEPFAR beneficiaries and staff) and Mitigate COVID-19 impact on PEPFAR programs and beneficiaries and support PEPFAR program recovery from the impacts of coronavirus.

The COVID-19 pandemic has had an adverse impact on Côte d'Ivoire's health care system, services, and care, for people living with HIV (PLHIV). Fear of contracting COVID-19 led to steep declines in clinical visits and community outreach engagement. Multiple COVID-19 outbreaks among PEPFAR Implementing Partners and beneficiaries resulted in the temporary shutdown of field offices, severely limiting the implementation of life saving programs and disrupting client services. Certain clinical facilities became COVID-19 treatment centers, and resultant task-shifting adversely affected HIV service delivery. PEPFAR Côte d'Ivoire continues to struggle with the global supply chain disruption that has increased commodity and logistics costs, significantly delayed deliveries, led to global shortages of key commodities such as personal protective equipment, and exposed the weaknesses of the national stock management system. Côte d'Ivoire's national laboratory network adapted by adding quality COVID-19 diagnostics delivery on platforms traditionally used for HIV viral load and TB testing. PEPFAR programs across the clinical cascade confirmed delays or the inability to execute critical health services when patients could not be found or contacted.

ARPA will enable Côte d'Ivoire's ability to prevent and mitigate the impacts of COVID-19 on PEPFAR programs and beneficiaries, as well as strengthen PEPFAR's response to COVID-19, HIV, TB, and other diseases of concern. PEPFAR Côte d'Ivoire intends to leverage ARPA funds to address the most significant programmatic challenges for providing quality HIV services, support program recovery, and accelerate the achievement of epidemic control. PEPFAR Côte d'Ivoire's Implementing Partner staff will receive necessary personal protective equipment, empowering them to deliver quality HIV services and oversee implementation activities. The supply of several commodities has been adversely affected by the COVID-19 pandemic. PEPFAR Côte d'Ivoire will leverage ARPA funds to procure specific commodities for COP21 that have been most affected, specifically TLD-90, DTG10mg, other essential medicines, and key lab supplies. The procurement will bolster the transition of TLD among PLHIV. ARPA will also support the resilience and recovery of the laboratory diagnostic network and bolster the national health information systems in support of the continuity of care for PLHIV.

Category (from list above: e.g., I-A for IPC)	Brief description of how support will be used	Relevant estimated targets (n/a if appropriate)	Agency	IM	Brief budget justification	Brief description of gap or need	Explanation of how this activity supports and complementary to national COVID-19 plans
I-A	Ensure safety of all PEPFAR implementing partners staff including sub-awardees through provision of PPE and IPC supplies.	All PEPFAR implementing partner staff including sub-awardees	CDC, USAID	All PEPFAR IPs. CDC: ACONDA, ARIEL, EGPAF, HAI, ICAP, IRC, SEVCI. USAID: ASAPSU, BLETY EpiC, JHU/BTA, REVE.	Procurement of IPC supplies (including PPE) for all PEPFAR IP staff including sub awardees	COVID-19 outbreaks among IP staff have led to at least 2 deaths and temporary closures (up to 14 days) of field offices with at least partial suspension of implementation activities on at least 4 occasions.	This activity directly supports the individual prevention measures recommended in the COVID-19 contingency plan for the National AIDS Control Program.
II-A	Support replenishment of stock for commodities depleted by the COVID-19 pandemic.		USAID	GHSC-PSM NPSP	Procurement of key commodities depleted as a result of the COVID-19 pandemic for	Need for TLD and other key commodities to support MMD and other COVID-19 mitigation measures.	This activity directly supports the TLD transition, 6-MMD and community ARV distribution recommendation in the COVID-19 contingency plan for

Category (from list above: e.g., I-A for IPC)	Brief description of how support will be used	Relevant estimated targets (n/a if appropriate)	Agency	IM	Brief budget justification	Brief description of gap or need	Explanation of how this activity supports and complementary to national COVID-19 plans
					COP21 implementation.		the National AIDS Control Program.
II-A	Guarantee availability of ARV stocks at the site level to support full rollout of TLD transition and MMD.	All PEPFAR-supported districts	USAID, CDC	NPSP, all CDC clinical IPs (ACONDA, ARIEL, EGPAF, HAI, ICAP, SEVCI), USAID: EPIC	One-time transportation and logistics costs for prepositioning of sufficient stocks to support 6-MMD at all PEPFAR-supported sites: $150,000. Transport and logistics costs for clinical partners to distribute stocks from district warehouses to clinical sites: $50,000.	Field visits and routine assessments by both GoCI and PEPFAR have shown insufficient site-level stock of TLD to support 6-MMD despite sufficient stocks at the central warehouse. This has led to lack of provider confidence in the availability of sufficient stock to support TLD transition and	This activity directly supports the TLD transition, 6-MMD and community ARV distribution recommendation in the COVID-19 contingency plan for the National AIDS Control Program.

Category (from list above: e.g., I-A for IPC)	Brief description of how support will be used	Relevant estimated targets (n/a if appropriate)	Agency	IM	Brief budget justification	Brief description of gap or need	Explanation of how this activity supports and complementary to national COVID-19 plans
						6-MMD and is a major limiting factor for 6-MMD uptake.	
II-B	Support diagnostic network optimization and ensure that pressure of COVID-19 diagnosis does not impede capacity.	Nationwide	CDC	TBD		National lab diagnostic platforms are not currently linked in a fully functional and optimized network.	
II-C	Support the development of a patient identity management system.	Nationwide	CDC	TAP MOH			